



JULY/AUGUST 1980

AMERICAN REHABILITATION



*60 Years
of Vocational
Rehabilitation*

THE WHITE HOUSE

WASHINGTON

March 26, 1980

The 60th Anniversary of the Federal Program of Rehabilitation celebrates a tradition of public service in which all Americans can take deep pride.

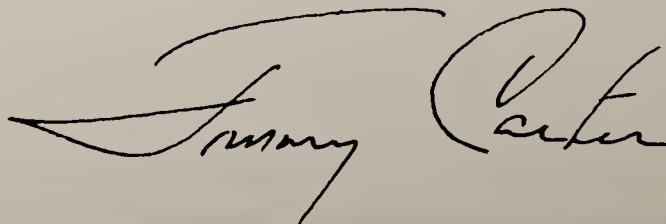
From its modest beginnings in 1920, when fewer than six hundred people were rehabilitated into employment, this Program last year provided services to over one million individuals, helping nearly 300,000 of them to independence and gainful employment.

Not only has the Program experienced strong growth, but it has also played a vital role in the success of other federally-assisted projects for our Nation's handicapped people. These include such efforts as to make buildings accessible to the handicapped; to assure the appropriate education of every handicapped child in the least restrictive environment; to prohibit discrimination against handicapped individuals in all federally-assisted activities; to open up greater housing options for the handicapped; to provide for them expanded employment opportunities with the cooperation of industry and labor; and to make available for them basic income support and health programs and assist them in becoming independent and contributing members of society.

Most recently, through extensive research into the problems arising from disability, our rehabilitation professionals have collaborated with their colleagues in other lands to find new and better ways of coping with common challenges in this area.

Honoring its commitment to human rights and human dignity, the United Nations has proclaimed 1981 as the International Year of Disabled Persons. In that year, all nations are asked to take steps to provide their handicapped citizens the opportunity for full participation and equality in their societies.

On this 60th anniversary of organized vocational rehabilitation in our country, we in the United States look with confidence to our public rehabilitation organizations to be in the vanguard of the movement that will ensure the best possible conditions and way of life for our handicapped fellow citizens.

A handwritten signature in dark ink, reading "Jimmy Carter". The signature is fluid and cursive, with the first name "Jimmy" and the last name "Carter" clearly distinguishable.

AMERICAN REHABILITATION

Volume 5, Number 6

The weakest ink is better than the strongest memory.

July-August 1980

3	Federal View of Rehabilitation	Robert R. Humphreys
8	Rehabilitation Medicine	Howard A. Rusk, M.D.
11	International Year Of Disabled Persons	Robert A. Leyton, Ph.D.
14	Rehabilitation Legislation	Kathaleen Arneson
18	Interview: CARF	
23	Expanding Lebanon's Rehabilitation Programs	Joseph LaRocca, Michael Dolnick, and William Lamprell
26	A View From The Transmitter	Thomas Brubeck
29	An Analysis Of Post Employment Service	Joseph Abrams

DEPARTMENTS

21	News, Notes, Announcements	28	Language Used
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Message From Senator Jennings Randolph

In this, the 60th year of the federal program of vocational rehabilitation, we can point with pride to the increasing number of handicapped individuals served, but we must not forget those individuals not being served whom we must serve. We can point with pride to the wide range of rehabilitative services and programs that have been developed, but we cannot be content with what has been achieved thus far. We have become increasingly aware of, concerned and responsive to the needs of disabled children, youth and adults, and our legislation in the field of rehabilitation for the handicapped reflects that awareness and concern. We have made progress toward our goal of bringing about a social, economic, and physical environment in this Nation that will enable each handicapped person to achieve his or her personal potential, but there is yet a long way to travel to achieve this goal.

The decade of the '70s, in particular, represented a period of optimism for handicapped Americans, and legislation proposed and enacted in that decade held out many promises. Unfortunately, not all of these promises were fulfilled. The 2 decade of the 80's offers new oppor-

tunities to enable handicapped Americans to participate more fully in the benefits of this society, but our experiences with the promises of the 70's cautions us to be more realistic in our expectations for the 80's.

The realities of the 80's may differ very little from the realities of the 70's, but our perceptions of these realities may need adjusting. Clearly, money will be tight as taxpayers continue to question the need for federal spending, but funds always seem available for programs of high national priority. Where a need is clearly demonstrated and where the benefits derived from federal expenditures are readily self-evident, the people of our Nation have always responded in a positive fashion.

The handicapped people are no longer the forgotten minority of a decade ago. The legislation of the 70's brought the problems of the handicapped into full view of the American public and along with this came a better understanding of the cost of full parity. We can no longer expect the appropriation of funds for services to the handicapped to pass automatically in both Houses of the Congress. If there is a single lesson to be learned from the 70's, it is that the

value of federal programs must be clearly documented and demonstrated. Increased funding in the 80's for programs serving the handicapped will require careful justification. The value of the vocational rehabilitation program is a matter of record; the need for its continued growth is without question. Our greatest need now is to focus public attention on what has been done in the field of vocational rehabilitation; what can be done; and what must be done. It has been suggested to me that Congress should appropriate each year the amount of money which it would have had to spend had it not been for the vocational rehabilitation program of previous years; that this amount should then be returned to the American public so that people would be more aware of the long term benefits of vocational rehabilitation. Obviously, that is not going to happen, but it does illustrate the great need for making the public more aware of the cost/benefits ratio of our vocational rehabilitation program.

Senator Jennings Randolph (D.-W.Va.) is Chairman, Subcommittee on the Handicapped, Labor and Human Resources Committee.

Past Success And Future Potential: A Federal View of Rehabilitation

Robert R. Humphreys

America has been witness to bewildering and profound change over the past 60 years. As time has passed during this period, change has accelerated exponentially across the spectrum of our economic, social, and political life. All of us are aware of the breadth and depth of the alterations that have occurred—the emergence of the United States as a superpower; civil rights; the Great Depression; Watergate; polio vaccine; heart transplants; television; computers and micro-miniaturization; and hundreds—no, thousands—of other developments of greater or lesser profundity.

Rehabilitation has not been exempted from the lightning—a fast change that has characterized the last 6 decades in this country. Though not as dramatic or as well publicized as many of the convolutions that have twisted and shaped our nation, the transformation of rehabilitation in America has nonetheless been massive and far-reaching.

From the perspective of the disabled person, change has been slow of attainment until recent times. But once change began for this population, it, too, has come in ever-accelerating waves. From almost complete isolation, pity, dependence, and paternalism early in this century

(just as in centuries past) disabled people have emerged from the darkness and are now awaiting—often with little patience—the completion of the metamorphosis to maximum independence (economic, social, psychological) and full acceptance, integration, and accommodation by the rest of society.

Though the path to realization of these goals often has been tortuous and replete with frustrations, it is clear that at the 60th year of rehabilitation, disabled people have considerably more to observe and celebrate than they did only a decade ago. Consider the following, abbreviated list of monumental legislative changes that have taken effect since the 50th birthday of rehabilitation:

- Individualized written rehabilitation program (IWRP) and subsequent IEP's and IHP's.
- Priority of service to severely handicapped people.
- Randolph-Sheppard Act Amendments.
- Developmental Disabilities Bill of rights and protection and advocacy system.
- Education for All Handicapped Children Act.
- Spinal cord injury model centers.
- National Council on the Handi-

capped.

- Title V of the Rehabilitation Act—the “Civil Rights Act” for people with disabilities.

- Tax credits for employers hiring disabled people, and for barrier removal.

A constellation of other improvements have been made through administrative and judicial changes, both federal and state. Technology breakthroughs have expanded the physical horizons of disabled people and the use of new devices has enhanced the social, communicative, and psychological competence of portions of this population. New drugs have ameliorated disabling conditions. Research in genetics has resulted in new testing and screening procedures related to mental retardation. Other biological research holds the promise of spinal cord regeneration or repair.

The White House Conference on Handicapped Individuals was more than a forum to palliate the concerns of disabled Americans. It was—and is—a blueprint for future action to be addressed by federal, state, and local governments, by voluntary agencies and the private sector, and by disabled people themselves. Federal agency plans for implementing the recommendations of the White House Conference are well underway. Peo-

ple with disabilities are becoming more vocal and more sophisticated in their self-advocacy, and as a result of that and other factors, a new awareness and sensitivity of the rights and needs of this population is growing throughout the land.

The White House Conference recommendations numbered in the hundreds. None is more important than that which proposes the formulation of a *national disability policy*. The development of such a policy would require us to conduct a top-to-bottom look at what we as a nation do for (and to) our disabled citizens. We would determine the full extent of existing program overlaps and counter-productive activity. We could identify with particularity major service gaps which inhibit the full development and societal and economic integration of disabled people. Such an activity would, I believe, demonstrate clearly that our emphasis on dependency, generating support and maintenance of people who are disabled, coupled with the relative lack of direct, *independence-fostering* services, results in largely insuperable obstacles to independence. We are thrust in a vortex in which dependence begets dependence, and in which the more we as a nation spend for such purposes, the more we require.

In recent months I have, in various addresses to constituent groups, borrowed an analogy (its source I don't remember) which points directly to the need for a national disability policy: The United States is a wealthy nation and its services to disabled people are many. We have a Maserati at our disposal, but its pieces are strewn around the floor of the garage. A national policy would enable us to put the pieces together and end up with a fine-tuned, high performance machine. I suspect, further, that even

straints and limited dollar and personnel resources, we would have a machine—a system—which delivers better services more efficiently and which more completely meets the needs of our disabled population than does the existing patchwork.

Two recent legislative activities will bear directly on the formulation of a national policy on disability. The 1978 amendments to the Rehabilitation Act (P.L. 95-602) established a National Council on the Handicapped, which by the time this article is published will be operational. The Council should play a major role in national policy development. The Department of Education Organization Act (P.L. 96-88) created an Office of Special Education and Rehabilitative Services, headed by an Assistant Secretary, which is destined to become the principal focal point in the Federal Government for matters relating to disability. This office should have the other major responsibility for national policy development.

Meanwhile, the Rehabilitation Services Administration has made some tentative forays into policy formulation, and some of the efforts of the Federal Interagency Committee for the International Year of Disabled Persons will be directed toward the subject. This group has an excellent opportunity, because of its makeup, to address cross-agency policy issues. Its membership consists of representatives of each cabinet-level department, as well as other major federal agencies who have responsibilities which impact on disabled persons. The members of the committee will have the advantage of following up on a year-long review of the White House Conference recommendations affecting their departments.

Prior to the establishment of the Education Department, RSA assumed lead responsibility in a num-

ber of major cross-agency initiatives, including the development of implementation for the White House Conference recommendations and the International Year interagency committee. Those assignments were based on the acknowledged experience and the mission of the agency in relation to disability. In addition, under the 1977 reorganization of the Department of Health, Education, and Welfare, RSA included the Developmental Disabilities program and the President's Committee on Mental Retardation, as well as the vocational rehabilitation programs.

With these added responsibilities came a natural elevation of the Rehabilitation Services Administration as a principal focal point in the Executive Branch on disability issues. This focus afforded me the opportunity to develop a conceptualization of what I consider to be a *facet* of that total national policy which is yet to be formulated. The following contain my thoughts (not recently reviewed or revised) on the need for a comprehensive national network of services for disabled individuals:

There is no system for the delivery of a continuum of services to disabled people in America. There are scattered programs which, with varying levels of adequacy, address different needs of these people. Some of these are directed to the special needs of disabled people, such as rehabilitation services and SSDI. Others are not disability-specific, such as Title XX (of the Social Security Act) and food stamps. Since there is no coherence, pattern, or plan relating to the provision of services, the needs of the *whole individual* are nowhere considered, and as a result there are both major gaps in services and pervasive, unmet needs.

In the absence of a comprehensive plan to meet those needs, it is a logical consequence that *capacity* is also

lacking on the part of federal, state, and local government, and in the private sector, to provide a full range of services to disabled people. In addition to the lack of capacity to meet needs, government and private funds have been spent on activities that are now perceived to be inappropriate. Other funds have been spent on services that are misdirected.

These deficiencies in policy, planning, services, and facilities all represent barriers to the full integration of disabled people into the mainstream of American society. Since these deficiencies have existed since our beginnings, disabled people, for the most part, have been sheltered and institutionalized. Because they are "different" from the able-bodied, they are all too often misunderstood, even feared.

Fear, misunderstanding, and a sheltered environment have resulted in a society that ignores or misperceives the needs of this population. Barriers, not only physical but also attitudinal, are the legacy of these long generations of neglect.

The task for society, then, is to begin to correct these longstanding inadequacies. Our mission is to provide a conceptual framework for their correction through a planned, comprehensive network for service delivery, and to begin to fill some of the gaps in services, service delivery capacity, to increase public awareness and to change attitudes.

The ideal structure for comprehensive service delivery would insure a continuum of service for all disabled people ranging from *preconception* through *senescence*. This implies the coordinated development of a capacity to provide five levels of care and service: Prevention, Maintenance, Amelioration, Habilitation, and Rehabilitation.

In order to insure continuity of services in a holistic framework, it is

necessary to provide a focal point in government to coordinate both the activities of service providers and the programs under which services are provided. As the principal federal agency with responsibility for meeting many of the needs of people over a full range of disabilities and levels of disability for people of all ages, it is logical to place this coordinative responsibility in the Rehabilitation Services Administration. As a point of departure, RSA should be given lead agency responsibility for the development of a national federal policy on disability.

Pending the development of a national policy, we can offer a conceptual framework for the building of a comprehensive service delivery network for people with disabilities.

Such a network would necessarily include institutionalization for those who are so profoundly disabled that no alternative living arrangements are feasible; independent living rehabilitation, including transitional living, congregate living, and halfway house accommodations, and a broad range of services to develop in disabled people who have no vocational goal the capacity to live independently and normally in their homes and communities; vocational rehabilitation for people, both severely and less severely disabled, who reasonably can be expected to develop vocational goals; and community based services, to insure that a continuum of services is available for all disabled people who are not in institutions. The level of services and the intensiveness of

IYDP News



Warming up for the International Year of Disabled Persons, two postal stamps have been issued by the German Democratic Republic.

such services would depend on the needs of the person. Many disabled people will need some services throughout their lifetime, which may not directly relate to the level of their disability.

It would be useful to indicate the range of services under these programs:

Community based services (all disability levels, all ages). Equal employment/affirmative action; transportation; recreation, public health-prenatal, postpartum testing, immunization; public safety; architectural barrier removal; tax abatements/financial incentives; integrative government/social service agency programs; public awareness and education; technical assistance to school systems/appropriate education assurance; and local information and referral, outreach.

Vocational rehabilitation services (working age population, vocational goals.) Counseling and guidance; restoration services; evaluation of rehabilitation potential; extended evaluation; vocational and other training services and materials; family services; provisions of aids and devices; placement and followup; maintenance during rehabilitation; interpreter and reader services; recruitment and training services; and transportation related to vocational rehabilitation services.

Independent living services (severely disabled, wide age range). Attendant management, attendant care; financial management; mobility and transportation; home management, chore services; medical maintenance and self-care; transitional living arrangements; social skills and problem solving; recreation; peer counseling; and sexual and personal adjustment.

living; physical exercise; social development; and educational development.

The vocational rehabilitation program has provided services through a state agency system for many years. Rehabilitation counselors, employed by the state, secure education, training, work experience, diagnosis, evaluation, and restoration services for their clients. Much of this is done through purchase of services from public or private rehabilitation facilities, manufacturers of aids and devices, physiatrists, psychologists, and businesses. Education and training and medical care can be coordinated through other programs, such as CETA, title XX, Medicare and Medicaid.

State developmental disabilities councils attempt to leverage and coordinate a wide range of resources for mentally retarded people and those with cerebral palsy, epilepsy, and autism, without regard to age or employability.*

Comprehensive medical rehabilitation centers provide rehabilitation services, primarily with a medical emphasis, to people outside the vocational rehabilitation system. These centers are located chiefly in hospitals and may be supported through foundations, as publicly-supported entities, or as private for-profit or not-for-profit operations.

Institutions for mentally retarded, mentally ill, or profoundly physically handicapped people are provided by state, city or county resources, and other public and private for-profit and not-for-profit agencies.

Community services and independent living services generally are not provided in a coordinated way. Larger cities may give attention to the specific needs of their disabled residents, and states have in a few cases established independent living ser-

vices through vocational rehabilitation agencies with state funds.

The link between vocational rehabilitation services and employment for those who have been rehabilitated has not been addressed in a major way. Traditionally, vocational rehabilitation agencies have viewed their role as one of *preparation* of the person for employment.

To create a nationwide network of comprehensive services to disabled people, mechanisms and delivery systems and coordination points must be established.

*The definition of developmental disability has been changed in law since this writing to one based on functional limitation rather than disabling condition.

- For community-based services, capacity building will be accomplished through regional, intergovernmental resource centers which will provide technical assistance, guidance on integrative programing, model ordinances, and public information materials. These centers will aid communities in their regions in developing community service mechanisms.

- For independent living rehabilitation, grants will be provided to state vocational rehabilitation agencies, to community-based organizations, to private nonprofit and possibly profit-making organizations, and to consumer organizations and cooperatives. Coordination with vocational rehabilitation agencies will be effected to transfer to the vocational rehabilitation program people who develop vocational goals as a result of their independent living rehabilitation. Information and referral mechanisms will be expanded at the state and local levels.

- The link between vocational

rehabilitation and employment will be forged through a major new cooperative effort with business, labor, and industry. Vocational rehabilitation agencies will work on a continuing basis with industry councils in major cities and industrial areas to match jobs and vocational rehabilitation clients, including job modification by employers to accommodate individual needs. Field testing, marketing, and distribution of new technology aids and devices will be developed. Cooperative commercial enterprises comprised of handicapped people will be supported for the purpose of developing and marketing products and services.

- States will be given an opportunity to develop a gatekeeping capacity to prevent institutionalization of people where such placement is inappropriate, to remove individuals from institutional settings, and to insure that for people for whom institutionalization is required, the best conditions are maintained.

- To insure that the rights of disabled people are safeguarded, and that voluntary compliance with laws protecting those rights is fully accomplished, technical assistance to states, government contractors, and recipients of federal financial assistance will be provided. Protection and advocacy systems will be expanded in each state. Community-based offices will provide counseling to disabled people on their rights under law, and on means to break down barriers that confront them in the environment. A nationwide client assistance program will provide ombudsmen for insuring that vocational rehabilitation clients receive appropriate attention to their needs.

- To eliminate fear, mistrust, and misunderstanding in the community so that attitudinal barriers and impediments to community support can

The momentum for making truly great strides in bringing disabled people into the mainstream of America must not be last.

be removed, community advocacy and information functions will be established through the regional centers described above. Public forums and discussions will be encouraged.

Many additional challenges face our government and our society in the effort to provide full quality and equality of life for America's disabled people. Among these are full use of technology, medical and biomedical advances in disability prevention and restoration; creation of a coordinated, nationwide program of deinstitutionalization; providing the fullest educational opportunity for disabled children through a fully coordinated Head Start—special education—vocational education—vocational rehabilitation program.

These are initial steps, but important ones, and they must be adopted if we are to realize our goal of filling the major gaps in services and the mechanisms to deliver them. The momentum for making truly great strides in bringing disabled people into the mainstream of America must not be lost.

According to oft-used estimates, there are 35 million Americans who have some level of chronic physical or mental disability. Of these, it is estimated that some 10.5 million may be considered severely disabled. This population is growing. As medical knowledge expands, our ability to sustain even those most severely disabled of our population also in-

creases. Addressing the needs of this, the "largest minority" may well become—and should become—one of the major national issues in the years to come. The manner in which these needs are addressed is the challenge to rehabilitation in the future, as it is to others who are concerned with the well-being of disabled people.

This year, 1980, marks the beginning of the new decade. I am confident that the next 10 years will see the realization of gains by people with disabilities which overshadow the improvements that have developed since 1970. Many of the foundations for this advancement have been laid; in law, in judicial decisions, and in the erosion of attitudinal barriers. Scientific advances will continue to multiply beyond the capacity of any one person to appreciate them all, much less absorb and understand them.

Yet those of us who have direct, urgent, and immediate interest in the future attainments of disabled people—whether we be parents, volunteers, federal or state providers, researchers, teachers, or disabled people—must be vigilant to insure that the gains which have been made over the years are consolidated, that the momentum is not slowed. We cannot be complacent nor satisfied with what has been done. Although I am optimistic, optimism must be tempered by caution and by an appreciation of the real world—its constraints and limitations—lest the optimism slip into unalloyed idealism. Further advances will not happen by themselves. Somebody has to make them happen. "Somebody," in this context, means all of us, working together for the attainment of a common purpose: maximum fulfillment of the human potential of every disabled American.

Mr. Humphreys is Commissioner, RSA.

Today, in a society that is so technologically precocious yet often spiritually adolescent, I often wonder whether we are facing the problems of sick people in a troubled world or troubled people in a sick world.

Rehabilitation Medicine: Past, Present, And Future

Howard A. Rusk, M.D.

My assigned title and frame of reference is boundless, REHABILITATION MEDICINE: PAST, PRESENT AND FUTURE. It seems logical to start with the past.

First, I want to give my own philosophy. Some months ago, I was asked what I thought the greatest advance in rehabilitation has been in the last 25 years. My immediate answer was that it has been the acceptance of a philosophy of responsibility that we in medicine are not finished with our patients when the fever is down and the stitches are out. We have a responsibility to restore severely disabled people to the best lives they can live within the limits of their disability, but much more important, to the hilt of their ability. Obviously, this is not just a medical responsibility but a *community* responsibility in its broadest sense.

Through the years, experience has taught us many things that should have been self-evident, one of which is that in our society physical wholeness and ability are not synonymous as we only pay for hand skill and brain power. We have seen through repetitive experience that properly trained and placed, the disabled workers have a better production rate, a lower absentee rate, and lower accident rates than the so-called "normal" fellow workers.

We have learned the hard way that there can even be an advantage to disadvantage. This is because nature has given us such tremendous powers of overcompensation. The blind man "sees" with his overdeveloped hearing. He can hear an echo and know whether there is a wall. You and I cannot hear it at all. He has super-sensitive fingers and you and I cannot even begin to feel the things that he feels. That is why he can read Braille and we cannot while we still have our sight. If we put our paraplegic patients at bench jobs that require upper arm strength and hand skills, they will outstrip the able-bodied workers in production because they are working the hypertrophied muscles with which they walk. Unfortunately, we have forgotten these simplistic things, but they are basic in the philosophy of rehabilitation and why rehabilitation works.

We also learned early in our rehabilitation programs that it was just not enough to meet the physical needs of the severely disabled, that the emotional, social, and vocational needs must also be met. This brought about the dictum that you must treat the Whole Man. To be more simplistic, it would be folly to spend 90 days to rehabilitate a paraplegic who had such an anxiety that he would not leave the house and then send him

home to a three-story walkup where he would be a prisoner for the rest of his life, or not to help him find a job that he could do within the limits of his disability but to the hilt of his latent abilities. The program must be comprehensive and total.

In the early days, orthopedic and traumatic disabilities were our primary problems, but there are as many and possibly more patients severely disabled from chronic obstructive lung disease and emphysema as there are from severe orthopedic disabilities. We have not even scratched the surface in cardiac rehabilitation, the scientific evaluation of energy requirements and how scientifically to prescribe a program in which the patient can operate safely within the limits of his own strength. This is actually a program of energy conservation. The aphasic patient must have precise speech evaluation and training, the laryngectomized patient has to learn esophageal speech, the amputee, in addition to being fitted with a proper prosthesis, must be taught to use it properly. Also, one must know the type and kind of patient who can benefit from and use the new sophisticated electronic devices.

In the past, the rehabilitation of the cancer patient has been greatly neglected. For example, patients after

radical mastectomy present not only the residual physical problem, which can be helped with proper training, but often severe psychological trauma, which can be prevented and managed. The same is true of the colostomized patient. A small pilot program was started some 10 years ago when we first recognized this problem of getting cancer patients back to work. Some felt that treated cancer patients, especially postsurgical patients, would be difficult to place because of the general fear of the word "cancer." The splendid results of many surgeons were well known and a high percentage of their patients were reaching a 5-year survival rate, which indicated an arrest of the disease. A small pilot study revealed that after 3 years, 80 percent of patients placed in jobs were still at work.

We have made great gains in rehabilitation services over the past 2 decades. The results of the rehabilitation of the spinal cord injured today are most heartening. At the Institute of Rehabilitation Medicine, New York University Medical Center, we have done two retrospective studies on the results in rehabilitation of the spinal cord injured. The first was done 5 years ago when 130 patients, paraplegics or quadriplegics who had been discharged 3 years or longer, were asked one question, "What are you now doing?" I predicted that if 15 percent were into some kind of life again it would be relatively good. We were surprised and delighted to find that 53 percent of these young people were either back in school or engaged in some kind of gainful work. Last year, we did a second study, the same number, the same question, and 83 percent were in school or at work. This is encouraging and has been due to a combination of better surgical techniques, better knowledge of nutri-

tion and skin care, and especially better urological management, as well as the development of electronics, including electric wheelchairs operated manually or by breath and, a voice-controlled wheelchair operated with a 30 command computer.

The voice-controlled wheelchair obeys the voice and the commands of the paralyzed patient so that he can go forward, backward, right or left, or operate in a slow jog if he is approaching a stopping place. It also operates an environmental control system that, in the office or at home, he can plug in from his chair and by voice command open the door, turn on the lights, turn on and change channels on television and stations on the radio, get the telephone operator and dial his own telephone number by voice, operate a page-turner, a special tape recorder for students so that they can tape a lecture or the answers to examinations, which makes their education so much simpler. The voice chair can be programed in any language, and research has now shown that it is possible to tape the voice of patients who cannot speak a formal language but have their own "sound language." However, with minimal training they can operate such a chair and the environmental control system with "their own" sound language. Countless numbers of these severely disabled people with this capacity can be unlocked from their inability to communicate and can be, to a certain degree at least, self-sufficient. What this would mean to the thousands of patients so affected and to their families is really beyond comprehension.

There is great hope for the future of our disabled with a total approach of service, research, and training, but the needs are great and the workers are few. There are less than 2,000 trained specialists in rehabilitation medicine

and there are estimated to be more than 7,000 position vacancies in the United States in medical teaching institutions, hospitals, community centers, and outpatient clinics. Increased training opportunities are a must if we are to fulfill our obligation.

It is my feeling that one of our major problems, both now and in the future, is those that deal with our aging population. I think that anyone who has given the subject any thought understands that age is physiological and not chronological. Some people are old at 50 and others are young in their 80's. The philosophy and the studies that have been made and the programs in action at the National Institute of Aging are heartening.

A recent publication of the National Institute on Aging, U.S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, states the problem most succinctly:

"Introduction—The twentieth century is one in which the problems of old age have become especially apparent. The vast increase in the absolute number and relative proportion of older people is perhaps the most startling demographic change of the last 75 years. Individuals over 65 comprised 4 percent of our population in 1900, nearly 10 percent in 1972, and will comprise a projected 17 to 22 percent of this country's people by 2030. In only 45 years, 1 out of every 5 Americans could be over 65. This explosion in numbers will have serious social, economic, and personal consequences if we do not make plans well in advance.

"In 1974 Congress recognized the need to establish the National Institute on Aging (NIA). New knowledge gained through scientific research conducted and supported by the NIA will help to improve the quality of life, enhance service 9

delivery to the old, and help contain rising health care costs. It is hoped that through a major commitment of time and effort we can unravel some of the mysteries of the aging process before our population swells with the children of the post-World War II 'baby boom' grown gray."

In my opinion, the greatest needs of the aged are to feel loved and wanted and have an opportunity to contribute to society. The greatest contribution they can make is to share their wisdom, which is our most precious human resource, for wisdom only comes with experience and experience only comes with time. A nation that can split an atom and put

astronauts on the moon certainly must have the social, psychological, and physiological capabilities to help in solving this complex human problem. If we accept the obvious need to marshal our forces and proceed with dedication, sensitivity, and compassion, the lives of our older citizens and ours, too, will be enhanced and enriched since the problems of aging have existed forever. We have much to learn from the past and present cultures and see how they have met these problems.

Today, in a society that is so technologically precocious yet often spiritually adolescent, I often wonder whether we are facing the problems of sick people in a troubled world or

troubled people in a sick world. The problems are indivisible and must be addressed both practically and philosophically. Working with others on a global scale will also pay great dividends in international understanding without which we can never hope to have a peaceful world. Rehabilitation in the foreseeable future must play a key role in solving these fundamental world problems.

Dr. Rusk is Director, Institute of Rehabilitation Medicine, and Professor and Chairman, Department of Rehabilitation Medicine, New York University School of Medicine, New York University Medical Center.

Living To 100

Richard S. Gubner, M.D.

If you can withstand the heritage of uncertain genes; if you can defy the hazards of prenatal life and development and the rude shock and adjustment of being born; if you can avoid exposure in your tender years to a vast number of unfriendly viruses and other pathogens; escape the teens without cracking up in a drag race; if you can endure your 20s without being a military casualty; get past the 30s without a slipped disk and through the 40s to 50s without a coronary, your prospects for reaching 100 years of age are reasonably good.

This presupposes that you have not abused your lungs too badly by excessive smog and smoking, not damaged your liver by drinking, and your wife (or husband) and job (or children) have not nagged you into high blood pressure, a troublesome ulcer or overeating with abandon as 10 an outlet for your frustrations.

If none of these have done you in by your 60s, there is little to concern you—other than capricious coronaries, blocked plumbing to your bladder and brain, or some unpredictably unruly cells which may get a wild urge to propagate without restraint. Anywhere along the line, of course, you might be a victim of an act of God, your own carelessness, or even some accidental error by doctor, nurse, hospital or drugs in ministrations to your health.

Barring such misfortune, you ought to get to an advanced age before the biologic clock runs down to a halt. This can only occur, however, if you have been provident and have a fair reserve of resources, companions and interests to keep you active.

If this grim recital makes your prospects of happy survival seem too remote, cheer up! You have already overcome all-but-impossible odds in

being born. If any other spermatozoon, competing against millions, had accomplished union with the ovum, the act simply would not have resulted in you.

Just don't follow everybody's advice on how to reach a ripe old age, even that of the centenarians themselves. Chances are they owe long life to long-lived forebears. If you've got that going for you, you just might make it too. Don't leave all the work to your ancestors, however; there is a little you can do yourself. A life of physical activity and abstemious habits, notably in diet, the net visible result of which is to keep you spare and trim, does seem conducive to longevity. The Greeks, of course, knew this. The shrine at Delphi, where the oracle foretold the future, had two simple inscriptions on its portal, "Know Thyself" and "Nothing to Excess."

The International Year of Disabled Persons

Robert A. Leyton, Ph.D.

In 1977, the 31st regular session of the United Nations General Assembly adopted a resolution proclaiming 1981 as the International Year of Disabled Persons. The aim of the year: to encourage the rehabilitation of the estimated 450 million people on Earth who suffer from some form of physical or mental impairment. Agreement was reached, in the General Assembly, that, during the year, there would be a focus on plans and activities directed toward the realization of five principal objectives:

- Helping disabled persons in their physical and psychological adjustment to society.
- Promoting all national and international efforts to provide disabled persons with proper assistance, training, care and guidance, to make available opportunities for suitable work and to ensure their full integration in society.
- Encouraging study and research projects designed to facilitate the practical participation of disabled persons in daily life.
- Educating and informing the public of the rights of disabled persons to participate in and contribute to various aspects of economic, social, and political life.
- Promoting effective measures for the prevention of disability and for the rehabilitation of disabled persons.

The United States, in accordance with the invitation of the U.N. General Assembly to all member states and concerned organizations to establish measures and programs con-

sonant with its broad objectives to celebrate the year, has established the theme that all people who have a handicap should have the right to live as independently as possible with full opportunities for participation in all phases of American life. This basic right includes five freedoms: FREEDOM TO LIFE, FREEDOM OF MOVEMENTS, FREEDOM TO LEARN, FREEDOM TO WORK, and FREEDOM OF INDEPENDENT LIVING.

United States participation in the year reflects its long established and active role in supporting national and international efforts to meet the needs of the hundreds of millions of disabled people in the world. This role includes its support of the principles of the Universal Declaration of Human Rights, the Declaration on the Rights of Mentally Retarded Persons, the Declaration on the Rights of Disabled Persons, the cosponsorship of the resolution proclaiming 1981 as the International Year of Disabled Persons, and—as one example of a national effort—its White House Conference on Handicapped Individuals.

President Carter, in expressing his support for the resolution, stated on June 22, 1979:

“The United Nations, honoring its commitment to human rights and human dignity, has proclaimed 1981 as the International Year of Disabled Persons. As President, I will see that those agencies under my jurisdiction join in this effort to give handicapped persons the opportunity for

full participation and equality—

“As a nation we can take pride in the contributions that persons with disabilities have made in such fields as medicine, science, education, the arts, law, journalism, the entire sweep of technological advances, politics, and government.

“We must seize the opportunity afforded by the observance of this International Year to increase public recognition of what remains to be done before handicapped persons are permitted full participation in the life of their communities. We need to erase residual prejudices and discriminatory actions and eliminate, where possible, the remaining barriers that still block their paths.

“Let us resolve to do this in a spirit of cooperation and understanding of each other's needs so that the International Year of Disabled Persons will achieve not only these objectives, but will bring about a new era of universal respect for human rights, including the rights of disabled persons.”

The White House recognized that effective United States participation in the year must involve:

- A wide range of federal departments and agencies whose programs affect disabled people

The White House recognized that effective United States participation in the year must involve: A wide range of federal departments and agencies whose programs affect disabled people; active participation by state and local governments; active participation by the private and 11

voluntary sectors; and a carefully designed planning phase—which would integrate the efforts of and inputs from each of the involved parties, as well as from representative disabled consumers—and a subsequent, well coordinated and effective implementation (program) phase.

Accordingly, the White House, through its Domestic Policy Staff, directed the formation of a Federal Interagency Committee, IYDP, to provide leadership to and coordination of this planning and implementation effort. Responding to this, the Secretary of State and the Secretary of the Department of Health, Education, and Welfare established the Federal Interagency Committee (FIC). In so doing, two cochairmen were designated: for domestic affairs—Mr. Robert R. Humphreys, Commissioner, Rehabilitation Services Administration, Department of Health, Education, and Welfare; for international affairs—Mr. John D. Fox, Director, Office of Development and Humanitarian Programs, Bureau of International Organization Affairs, Department of State.

The committee consists of representatives from over 25 federal departments, agencies, offices, and commissions; the Executive Office of the President; and the United States Mission to the United Nations.

The committee has established five major objectives:

- Furtherance of the development of a U.S. policy on disability that will maximize coordination and minimize conflict and overlap in federal policies and programs dealing with disability.

- Promotion of research, demonstration, service delivery, policy, and planning activities throughout the federal government that are directed toward improving the quality of life for individuals with disabilities.

- Development of an awareness throughout the federal government of the needs of people with disabilities—and the application of this awareness in the planning, implementation, and assessment of all federal programs that impact upon these people.

- Furtherance of the development and implementation of programs to educate and inform the public and private sectors of the rights of disabled persons to participate in and contribute fully to society.

- Fostering the implementation of human rights.

The committee functions by serving as a forum to discuss—and to develop recommendations on—actions to meet each of its objectives; and serving to facilitate, promote, coordinate, monitor, and assess agency and committee activities directed to the attainment of its objectives.

Subcommittees have been formed to address and serve as a focus for planning and implementation in three areas: policy analysis, development, and coordination; awareness and education; and special activities—to celebrate and observe the year.

In addition to the committee and its subcommittees, the Federal Interagency Committee includes:

- A Steering Committee that is comprised of the two committee cochairmen, selected members from the full interagency committee, and staff from the Department of Health, Education, and Welfare and the Department of State.

- A Federal Secretariat that is charged with the management and coordination of all federal IYDP efforts and the provision of all liaison with other federal departments, agencies, commissions, and offices in each of the three branches of government; with state, county, and local governments; nongovernment organizations; and with the public.

- Intra-agency committees in each of the IYDP member federal departments and agencies. These committees are chaired by the agency's representative on the "parent" IYDP Federal Interagency Committee, and is comprised of people responsible for personnel policies and programs, public relations, legislation, and all other major activities and programs of that organization. Each is mandated to both plan and carry out a program and activities for that organization to observe the International Year of Disabled Persons.

The committee, which is presently involved in the development—over the next 3 months—of an integrated plan of activities and actions, will not only serve to observe and celebrate 1981 as the International Year of Disabled Persons, but will lay the groundwork for actions and activities during the 1980's, a time when the dreams and aspirations of disabled people may finally coincide with reality.

The years just ahead present unparalleled opportunities for government, voluntary agencies, business, and labor (as well as private citizens) to help people with disabilities advance their quality of life. More importantly, it is a time of opportunity for disabled people to help themselves achieve a fuller life. The International Year of Disabled Persons can be a major foundation upon which the building blocks of policy, awareness and education, disability prevention, financial and other support maintenance, impairment or disability amelioration, habilitation and rehabilitation, and the furtherance of human rights can help achieve this fuller life for our disabled citizens.

The Federal Interagency Committee encourages each person, each

(Continued on page 27.)

EVERY DAY IN THE U.S., about 1,000 handicapped people are rehabilitated to employment. The process of rehabilitation is as varied as the people we rehabilitate. Each state has its own success stories. Begin putting these stories together for the year of disabled persons.

Every
Day
In The
U.S.



INTERNATIONAL YEAR
OF DISABLED PERSONS, 1981



Rehabilitation Legislation: The Drama, The Script, The Players

Kathaleen Arneson

Authors of fiction maintain that to write a serious novel, one must choose a mighty theme and write about significant people working through events that give life to the story.

It seems to me that there are parallels in writing about legislation and the social programs. Thus, the mighty text or theme of this nonfiction story is the fact and significance of the 60-year old federal law which underlies the federal rehabilitation commitment. This commitment is to finance rehabilitation services to help handicapped people prepare themselves for vocational and other self helping activities. Such services are often basic to their entry or return to employment, maximum independence, and constructive interdependence in their daily lives.

The heroic people in the story are the people with physical or mental impairments which result in their being handicapped in substantial ways from pursuing their aims. These are in getting an education, training, jobs, and a satisfactory place in their communities as ordinary, productive people. The other key people in the story are members of constituent and provider groups whose members make "rehab services" come alive by using their skills and their human capability for interaction with the impaired people. Most importantly are the family members of the disabled person who are part of the human, support services that sustain the

handicapped person in the course of his rehabilitation. Enabling handicapped people to get into programs and carry on those interactions are dedicated members and staff of the legislative bodies at all levels who prepare and enact the legislation which makes possible the development of the rehabilitation programs. There are, also, thousands of people who play parts in the unfolding drama of the preparation and implementation of an individual's "Written Rehab Plan." And each plan may be thought of as a scene in the rehab story as a whole.

All other people in the scenario are actors, playing parts that are peripheral but important to the delivery of the services. These include program administrators; counselors; researchers; educators who train the doctors, therapists, evaluators, secretaries, nurses, and aides; and all others who have a role in the development of the services and their delivery to the client. Community people, volunteers, employers, union officials, and fellow workers who are concerned about providing jobs and overseeing the rights of disabled people are part of the play, too.

The people thus described in the program and those facilitating its implementation are involved because of the federal Rehabilitation Act of 1973, as amended. Such people are organized into the systems of services and activities authorized by successive enactment of rehabilitation

laws since the program began 60 years ago.

The Act has made possible a constellation of services, rights, and programs with authorizing programs organized into Titles and Parts of the Act as follows:

Title I—Vocational Rehabilitation Services

Part A—General Provisions

Part B—Basic Vocational Rehabilitation Services

Part C—Innovation and Expansion Grants

Part D—American Indian Vocational Rehabilitation Services

Title II—Research

Title III—Supplementary Services and Facilities

Part A—Miscellaneous Programs

Part B—Special Projects

Title IV—National Council on the Handicapped

Title V—Miscellaneous

Title VI—Employment Opportunities for Handicapped Individuals

Part A—Community Service Employment Programs for Handicapped Individuals

Part B—Projects with Industry and Business Opportunities or Handicapped Individuals

Title VII—Comprehensive Services for Independent Living

Part A—Comprehensive Services

Part B—Independent Living Centers

Part C—Independent Living Services for Older Blind

Part D—General Provisions

Part E—Authorizations

Change in the Act During the Early 1970s

In the early 1970s, the Congress and the Administration separately developed new proposed amendments to the Act. It had been amended most

recently in 1968. This event is recorded in the *Rehabilitation Record* of 10 years ago in an article I wrote on the legislative situation in 1970 which was the 50th anniversary of the program.

There was a marked difference, however, in the situation in 1968 and 1971-73 and in 1978. During this time discussions were held, new bills were developed, subjected to hearings and voted up or down. Readers who followed this legislative period of dealing with rehab issues will remember that the significant differences were:

(1) The growing adversarial character in relations between the executive and legislative branches of government—a condition that enveloped the whole process of amending the Rehabilitation Act.

(2) The participation of increasingly greater numbers of handicapped people and organizations in the federal legislative process. This was accompanied by the tendency of many groups to advocate primarily for their own disability groups.

(3) The new tendency of the states to concentrate on their particular state's needs and develop collective approaches different from those of "the Feds."

(4) The tendency for some groups to prepare their legislative positions and proposals without the usual policy consultations with federal executive program and political leaders. This produced a gradual but temporary isolation of the executive development of proposals from those of key constituent groups. As a person involved, I can identify the period of the first half of the Nixon/Ford Administration as a turning point in the heretofore amicable working relationship on rehabilitation matters between federal and state executive and federal legislative staff and committees.

(5) A buildup in the Department of HEW and the Social and Rehabilitative Service of cadres of political and management staff was occurring. Their mission seemed to emphasize unduly, "control" and "program integration" despite statutory requirements, and prohibitions that prevented consolidations.

(6) Beginning of "reorganizationitis" that resulted in some effective programs and their federal organizational bodies being wiped out, made less effective or merged with other units. An example was the dismemberment of the U.S. Children's Bureau which exists now primarily as a part of another agency. Doubtless, the process also stimulated successful reorganizations and appropriate abolitions of obsolete programs and offices.

(7) A trend to amend substantive legislation to deal with civil rights issue—as exemplified by Title V programs, the Individual Written Rehabilitation Program, Projects With Industry, and programs for protection, advocacy, and client assistance.

(8) Seemingly, a growing reluctance of the Office of Management and Budget to support and expand programs to cover more eligible people even though the programs were proven to be cost effective and returned more to the federal treasury than they cost.

The major Presidential and Congressional initiatives incorporated in legislation establishing the federal Education Department and in the 1978 legislation (despite the climate of opinion noted above) have both caused and reflected new federal policy positions in behalf of disabled people. These thrusts culminated in increased authorizations in the Rehabilitation Act of 1978 and altered the emphases in existing programs and

activities. They are, however, solidly based on the major changes and initiatives in the legislation of 1973.

They are:

(1) The expanded independent living programs in Title VII;

(2) The new community employment program in Title VI;

(3) The expanded coverage of the civil rights Title V to cover more community activities and facilities, including federal activities themselves as well as federally assisted activities and services;

(4) Expansion of the 1973 emphasis on involving industry and business in serving and employing disabled people;

(5) Beginnings of greater reliance on local communities organizing to assure employment, civil rights, and services. Experiments are possible under the pilot projects of the soon to be activated comprehensive rehab centers program;

(6) The greater emphasis in the research title, Title II, on the use of technology to contribute to the solution of problems of handicapped people;

(7) In Title II, greater involvement in policymaking at the federal level for nongovernmental leaders by establishment of the National Council on the Handicapped.

(8) In Title I, the substantial increases in federal authorization levels for the basic state-federal program of vocational rehabilitation services, and the entitling of states to sums of federal money for their programs;

(9) Congressional recognition of the drastic impact of inflation on service levels by building into the statute a consumer price index factor in the authorization for federal funds;

(10) The building in of significant consumer involvement in policy developments in the state VR programs;

(11) The effect of the legislation establishing the Education Department which broke up the existing collection of programs for handicapped people under the Rehabilitation Services Administration. This was the separating out of the Developmental Disabilities Program and placing it in the Department of Health and Human Services, while the major federal service programs for disabled civilians were incorporated in the Education Department. This followed closely in time the other major movement out of RSA of its rehabilitation research capability, as part of a plan to develop an independent and comprehensive National Institute of Handicapped Research.

Administrative and Management Changes to Come

Current discussions and activities suggest to me that, given the needed resources, some or all of the initiatives mentioned below will be undertaken to help improve federal services for handicapped people.

(1) There will be closer program relationships in the next decade between vocational rehabilitation services specialized education such as vocational education, special education and adult education. The President's Youth Initiative legislation of 1980 and the 1982 reauthorization of the vocational education program are moves that can contribute to fashioning improved connections between these programs at the community level.

(2) Greater use by the Rehabilitation Services Administration and state agencies of basic health, welfare, education, and rehabilitation programs for handicapped children, adults and older people through statutory tapping of certain funds for disabled people, better administrative planning for administration of these

basic community services, and interagency agreements. This would include joint work to meet the problems of people who come to one service but need the help of more than one.

(3) Greater emphasis on adequate management information gathering and use and on rehabilitation evaluation. Congressional Budget Office studies, GAO reports, and general audits have shown where improvements can be made. There are intensive efforts to make all governmental units more accountable in an era of rising public expectations and rising costs of serving people effectively.

(4) Greater program emphasis on development and use of rehab technology, and upon cross fertilization of elements among service programs. Initiatives, for example, from legislation for services for older populations will be showing up in provisions for handicapped people in the basic Rehabilitation Act, as amended.

(5) Greater borrowing and adapting of ideas and practices from European experience and that of other countries. An example is adaptation of transportation and housing concepts from Europe. The approach of total accessibility originated in the U.S., and paratransit transportation services for special populations such as Dial-a-Rides originated abroad.

(6) The policizing of the rehabilitation movement, and the increasing militancy on the part of the disabled which might be expected as funds for these programs grow. Examples are the formation and early support of the League of Disabled Voters; national efforts to encourage localities to make all polling booths accessible to disabled people; and the approaches to political candidates to respond to questions and demands of organized groups of disabled people.

(7) Increasing attention will be given to developing means of using

the results of research and modern technology in current practices of delivering services. There will be more attention to attitudinal barriers and resistance to change because these tend to slow up modifications in ways that communities respond—or don't respond—to the needs of its vulnerable populations.

(8) Research developments may move from single research projects to greater emphasis on systems of research and demonstration, *i.e.*, to plan sequential projects to arrive at knowledge and recommendations sufficient to provide answers to specific service delivery problems. An example: evaluating what a large problem such as improving services to the deaf really requires in new facts: new and better preparation for service personnel, including interpreters, teachers, counselors, and employers trained to communicate with the deaf; cheaper and better machines (TTYs and other items) more widely available; and a physical and attitudinal environment sensitized to the special needs of deaf and hard of hearing people.

Program Development

(1) There will be a continuation of the partnership between client advocacy, federal legislation, and federal and state executive leadership in policy development and expansion of state and federal and community resources to help the handicapped.

(2) There will be a continuation and resolution of current controversies on how best to provide for all people: frail older people, disabled adults of employment age, and handicapped children and youth in schools. Clearly the civil rights/transportation issue will produce no single national policy other than ultimate access of all federally funded systems. Equally, it seems evident that the differences in communities with their

varying numbers and needs of disabled people will result in the evolution of various types of locally financed community systems. Each will seek to solve the mobility needs of older and impaired people as well as the needs of younger people. Solutions will differ markedly because they also reflect geographic and economic constraints.

(3) There will be a continuation and expansion of the self-help concept. This will be exemplified in the further development of independent living services and centers with many different models. This could give rise to companion self-help activities in the economic sphere with the creation of more consumers' and producers' cooperatives of and for handicapped people and community development projects by handicapped people.

(4) There will be even greater emphasis on integrating disabled people, *i.e.*, encouraging the greatest use by them of regular commercial and community services instead of the development of para-transit and/or isolated education and other services solely for people who are disabled. There will be an equally important appraisal of the effects of mainstreaming, including (a) how community services must be geared to serve people in their own homes and prevent premature or unwarranted institutionalization and (b) how communities can resettle and be helpful to people returned from institutional care.

(5) A parallel trend to mainstreaming will be a growing recognition, and acceptance, of the fact that not all handicapped people are able to cope with these essentially competitive situations in the community. Many towns and cities are not yet fully sensitive in or responsive to the requirements of people with lessened physical stamina or skills. Accord-

ingly, I believe there will be less insistent advocacy for "full accessibility and total mainstreaming" and perhaps a greater recognition that choices need to be made according to the real needs of the individual disabled people in question. Institutional care may still be needed by some people and, accordingly, there should be no let up in efforts to improve such care for people who need it.

(6) Financial constraints and common sense will lead policymakers, including members of Congress, to examine more closely the disincentives in the federal policies affecting disabled people and their employment. Indeed, the larger issues of cost-benefits in the total system of services for people with handicaps will be subject to searching analysis. Some of the issues and facts have surfaced in testimony and papers by the Commissioner of the Rehabilitation Services Administration, by GAO studies, and university-based research experts. What is needed now is a decision to put the evidence together. Policymakers at the highest Congressional and Executive levels need to assess the implications of the facts and formulate a series of administrative and legislative reforms to accomplish necessary changes.

The Education Department and the Department of Health and Human Services have the data, interagency structures for cooperation, and a new National Council on the Handicapped to assist in the process. Based on its recent record of attention to issues like this one, it can be assumed that the Congress will be interested in considering new solutions.

(7) Increasingly, local community services for disabled people will be initiated at the service delivery level. There is a trend toward creating local solutions to the impact of national problems (*i.e.*, pollution, energy,

credit, and civil rights). There is an inclination now for local groups to work on essentially local permutations of problems and solutions which affect disabled people. Examples are integrated classrooms, accessible shopping and dining facilities, local government employment opportunities, barrier free and affordable residential accommodations, and parks, polling places, and parking facilities useable by handicapped people. The use of authority in the Act for comprehensive rehab centers could hasten and help guide this process.

(8) Estimates that about a fifth of the chronic unemployed have disabilities will give emphasis to remolding employment opportunities and manpower training legislation and programs. This should include the activation of Title VI of the Rehabilitation Act by the Department of Labor. We can expect more pressure to implement the affirmative action provisions of Title V of the Act, and possibly some changes in the CETA program to enable it to serve greater numbers of disabled people.

(9) Many more state and local leaders are beginning to recognize the economic and social values of investing greater amounts of resources in putting people back to work and of keeping them at work. Political leaders know that human values and dollar constraints combine to give more support to the idea that it is constructive to help all sectors of the community engage in appropriate work and self help activities. We can assume that legislators will continue to consider new legislative proposals to achieve these goals, and to monitor closely the programs they have already established in law.

We must extend the success of the

(Continued on page 22.)

Interview:

Commission On Accreditation Of Rehab Facilities

The Rehabilitation Services Administration (RSA) is committed to the delivery of quality rehabilitation services to the millions of handicapped men, women, and children in this country. Not only does this vital segment of our population deserve the same opportunities afforded all citizens, but, in addition, they represent an invaluable resource that can productively impact on our society.

RSA recognizes the position of facilities in maximizing the potentials of disabled people. This network of programs, designed to respond to specialized needs and goals, represents a building block in this nation's rehabilitation movement.

However, as important as these efforts are, they must be carried out within the reality and demands of the times. The public and private sectors must not only be responsible for assuring the results achieved by the consumers of facilities' services, but also the job must be done in a more efficient and cost effective manner. The economic constraints and accountability expectations require evidence of facilities' continued capabilities and competencies.

Since the early '60's, RSA has been a strong advocate of the role of the Commission on Accreditation of Rehabilitation Facilities in the rehabilitation facility movement. The 18 Federal Government has supported

the principle of the private sector promulgating and applying standards through a nationwide accrediting process. This form of quality control is essential in improving facilities' performance, and upgrading the outcomes of its services.

Because accreditation has become such a necessary part of facility's operations, we wish to highlight points covered in an interview with Alan H. Toppel, Executive Director of the Commission.

Q. Specifically what is the primary purpose of the commission on accreditation of rehabilitation facilities?

A. The Commission actually has several purposes. Ultimately our goal is to ensure that disabled people receive rehabilitation facilities services that are of the highest quality and responsive to their needs. The Commission functions as the quality control intermediary for the rehabilitation facility movement. In this capacity, we define the standards of performance for facilities and serve as a vehicle to upgrade the delivery of services to disabled people.

Q: How do you accomplish this mission?

A: We do this by establishing standards for the total operation of

facilities; carrying out site surveys in which the standards are applied, and the facilities are held accountable for their compliance. Further, the process of resurvey of previously accredited facilities creates an ongoing climate of accountability for positive change and growth. Increasingly, accreditation has become recognized as both a demonstrated level of competence and as an expectation on the part of all quarters of the rehabilitation movement.

Q: It has been our observation that accreditation reports in most fields of human services have taken many, many years to attain the level of recognition and impact that the commission has been able to accomplish in a relatively short time. How do you account for this?

A: I think there are several reasons which are at the heart of the Commission's success. Changing events and circumstances that have shaped the course of rehabilitation and the serious economic pressures which have created accountability demands are factors that have played an important role in our unique value to the field. As critical as these factors have been, of equal significance are the support and commitment of key individuals

and groups. No one was more instrumental than Mary E. Switzer in recognizing the need for an independent standard-setting and accrediting body and in facilitating its creation. In addition, the Commission has benefited from the steadfast support of our sponsoring member organizations, the Department of Health, Education, and Welfare and, particularly, the invaluable assistance of the Rehabilitation Services Administration, the Council of State Administrators of Vocational Rehabilitation, and other rehabilitation organizations, and individuals who have come forward to participate in accomplishing our objectives.

Q: *You mentioned the sponsoring members; who are they and what role do they play?*

A: The Commission was founded originally by the two predecessor organizations of what is now the National Association of Rehabilitation Facilities. Since that time, the American Hospital Association, National Easter Seal Society, Goodwill Industries of America, and the National Rehabilitation Association have become sponsoring members of the Commission. It is a joining together of national organizations in a union of purpose that provides another vital dimension to the Commission's growth and acceptance in the rehabilitation movement. These organizations have a common belief in the value of an independent, impartial mechanism to establish standards and render accreditation decisions. A good example of the extent of this commitment are the policies of the National Easter Seal Society and Goodwill In-

dustries of America requiring their affiliates and local units to be accredited by the Commission.

Q: *You mentioned independence; how can you maintain this and still be an integral part of the system?*

A: That is a major issue that must be faced by any accrediting organization. CARF has responded to this by developing policies and procedures which assure our independence in primary areas of our activities, such as the final decision on the establishment of standards, conducting the on-site visits, accreditation decision-making, and the establishment of basic corporate policies. It is essential that we maintain a sensitive balance that allows us to have a productive relationship with all sectors and, at the same time, preserves our credibility which comes from a position of objectivity and impartiality.

Q: *Tell me about the Commission's standards.*

A: In the truest sense, these are not the CARF standards, but are the productive and collective thinking of all sectors of the rehabilitation movement. Specifically, the standards cover nine basic facets of the operation of a rehabilitation facility; these are purposes, organization and administration, services, personnel, records and reports, fiscal management, physical facilities, community involvement and relations, and program evaluation. Within each of these sections, certain standards have applicability to all facilities, regardless of the programs they provide or who they serve. Other standards have been established to address the uniqueness of specific rehabilitation programs.

Q: *What kind of programs do the standards relate to?*

A: Programs for which the Commission has established standards are in- and outpatient medical rehabilitation programs; personal and social development programs such as independent living, residential, psychosocial and habilitation centers; vocational development programs, including vocational evaluation, work adjustment, and job placement; sheltered employment and work activity programs; and speech and audiology programs. These standards are applicable to public, private, and for-profit organizations, free-standing and rehabilitation programs within larger settings, and are pervasive in terms of the applicability to the multiple disabilities served in rehabilitation facilities.

Q: *How are they developed?*

A: The Commission has consciously structured its efforts for reviewing and modifying standards to provide every opportunity for the broadest possible involvement. Beginning with National Advisory Committees that are convened annually for this purpose, we include a cross section of representation and expertise of consumers, purchasers, and providers to make recommendations for improvements. We continue to turn to different people each year to serve in this capacity. Following the Committee's work, proposed standard changes are shared with literally thousands of individuals and organizations for comments, including accredited facilities, national and local associations, federal and state government officials, consumer representatives, surveyors, etc. It 19

is only after the Commission's Board has had the benefit of this extensive review and response that they take final ent on on the standards.

Q: *How do you know the standards are relevant?*

A: I think that the very process which the Commission uses to develop the standards assures this. In effect, the breadth and depth of the development and review efforts place in the hands of all who are associated with the rehabilitation movement the capability to maintain the relevance of the standards.

Q: *How do you use these standards in the accreditation process?*

A: First and foremost, the standards are used by facilities in their own organized, self-evaluation efforts. Following this crucial use of the standards for self-improvement, the standards are applied in the on-site survey process by the Commission's surveyors. Finally, the accreditation outcome is based on the extent to which the Commission finds the facility meets the standard.

Q: *What is the primary benefit of the survey process?*

A: In this instance there are multiple benefits. These include an ongoing monitoring of the performance level of facilities; program upgrading which results from the process of resurvey, when facilities are held accountable for implementing previous recommendations; the value of peer review; the educational and consultation opportunities which are an integral part of the process, just to name a few.

Q: *The Commission does not employ full time surveyors. I would be interested to know why not?*

A: Recognizing that there are advantages and disadvantages to both approaches, we are philosophically committed to using people who have other primary responsibilities in the mainstream of rehabilitation. The chief advantages are a maintenance of the objectivity of the survey and accreditation process because of their employment independence from the Commission; their proven effectiveness in rehabilitation facilities; the opportunity to match the particular skills and experience of the surveyors with the unique characteristics of the facility; and, finally, the economic advantages which include the ability to accommodate to monthly fluctuations in survey volume and geographically related demands, and the cost benefit advantages that accrue in terms of the level of surveyor experience which can be obtained for the dollars expended.

Q: *You have been recognized for your efforts in program evaluation; why did the Commission initiate this?*

A: It was clear in the early 70's when the Commission began to surface in the area of program evaluation that there were increasing demands being placed upon facilities which could be met through the measurement of service outcomes. Also, we believed that the accreditation system has a responsibility to not only deal with the inputs and process taking place in facilities, but also with the outcomes of the delivery system.

Q: *What is your objective in this area?*

A: To see that the measurement of

service outcomes become an integral part of the operation of facilities throughout the nation. Through program evaluation, facilities now have a significant tool which enables them to aggressively respond to accountability demands, increase community support, and most important, to improve the benefits achieved by the people they serve.

Q: *What is the future role of the Commission in program evaluation?*

A: We see no lessening of the conditions and pressures that precipitated the need for our original involvement in this area. In fact, if anything, the focus on accountability appears to be looming larger and larger. On that basis, the Commission unquestionably can be expected to exercise continued strong leadership in program evaluation.

Q: *You have talked about accountability in terms of program evaluation for facilities; at this point, what comes to mind is, who holds the Commission accountable?*

A: If you are looking for one single entity that carries out this function, it does not exist. To have another organization established to do this would have the effect of compromising the independence and objectivity in standards setting and accreditation decision-making. On the other hand, that does not mean that we do not have to respond to accountability demands. The very nature of our wide-ranging involvement with the public and private sectors makes it essential that we be able to account for and justify our product and our process to
(Continued on page 22.)

Statement Of Representative Paul Simon

Since the inception in 1920 of the partnership between the states and the federal government in vocational rehabilitation services, this program has been the foundation for the national effort to rehabilitate disabled people. A relatively modest investment over those sixty years has meant for handicapped individuals the right to live as productive, contributing members of society. The vocational rehabilitation program has been one of the most effective and beneficial programs we have. The overall achievements of the vocational rehabilitation effort demonstrate the value of continued investment in these services.

Looking ahead, we must affirm our country's promise to its disabled citizens: to improve the employment and daily living potential of handicapped individuals; to maintain the integrity of the vocational rehabilitation program; to support research activities affecting the lives of handicapped people; and to guarantee to disabled people the full and rewarding life which is our nation's pledge to all Americans.

Rep. Paul Simon (D-Ill.) is Chairman, Subcommittee on Select Education, Committee on Education and Labor, U.S. House of Representatives.

NEWS, NOTES, ANNOUNCEMENTS

Simplified Planning Has Some Appeal

What began as notes scribbled on the back of a paper matchbook ended as notes on a matchbook—but distributed over a wide area.

"Communicating" first appeared in the July-August 1979 issue of *American Rehabilitation*. The short article includes a sketch of an open match folder, and printed on the folder is a "minimum public information plan" for state vocational rehabilitation agencies. (It is no coincidence that Tom Brubeck, who writes the magazine's "Notes on the Margin" column, has been the person writing on the back of a matchbook.)

The article was picked up by *Public Relations Journal*, published by the Public Relations Society of America. *American Rehabilitation* also received requests to reprint from *Rehabilitation International*, *Canadian Reporter* (Canadian Association for the Mentally Retarded), *Daystar* (a news journal of neurosis, psychosis, and retardation), and *OHD Exchange* (an HEW newsletter).

Info Center At Moss Rehab Center

A Regional Resource and Information Center for Disabled People is being established at Moss Rehabilitation Hospital in Philadelphia, and will be housed at Moss' Hassel Library. Grant money will be given in two yearly installments from The William Penn Foundation.

The resource center will serve as a repository for printed and audio-visual material on all aspects of physical disability, special programs, services, facilities, and benefits for handicapped people. Included in its collection will be data dealing with topics such as legal rights, adapting one's home for wheelchair accessibility, travel options, and clothing designed for a person in a wheelchair.

The center will be architecturally accessible and will have special communications equipment for people with hearing and visual impairments.

The services to be included will be telephone and mail-order reference service; interlibrary loans and photoduplication; film previews; workshop development; a newsletter for center users; and creation of original materials, where needed. The collection will include books, magazines, pamphlets, reprints, cassettes, videotapes, films, large-print materials, and physical models. A Travel Information Service, which has been in operation at Moss for a number of years, will also be part of the resource center.

An additional new component of the center will be a pretaped telephone information system called "Rehab Line." The only one of its kind in the Nation, the system is being developed by Moss. This multichanneled system will contain taped messages, from 3-to-6 minutes in duration, on topics of interest to disabled people. The messages will be presented in non-technical language and will be available in printed form as well.

Legislation

Continued from page 17

rehab movement in creating new alliances in the community, developing mutually helpful cooperation between private facilities and public programs, and the activation of many community interests in behalf of disabled people—such as Quota and Kiwanis clubs.

We expect that state vocational rehab agencies will continue to press for sufficient federal and state resources to develop diversified employment alternatives. Also, they will seek to serve again not only the most severely disabled who by law should be aided first, but all disabled people who need services to find work or stay employed. This may well renew the interest and the capability of more rehabilitation centers to offer, for a fee, a sophisticated client evaluation to assist any prospective client of any local human services program (welfare, mental health, older persons, returnees from institutions) in developing a pre-vocational and a vocational plan.

(10) A major change could be forthcoming in manpower training. Changes would respond to the now apparent needs of universities and colleges for older and handicapped students to replace thousands of students lost as a result of changing demographics.

Program developments will reflect how society generally, the academic community and the service delivery systems articulate their needs and demands for greater numbers of doctors, administrators and therapists for work with disabled people. One can assume a greater emphasis on peer group training, and training of older workers and disabled people to man
22 the service delivery system.

(11) A review of civil rights provision for all at risk populations is likely. At the Federal executive level this could result in the consolidation by law of administration of compliance and many of civil rights efforts and programs in the Department of Justice or a separate rights agency. This would leave to other federal agencies the equally responsible task of providing technical assistance to enable local groups, community agencies, businesses and schools to improve their capacity to help disabled people and non-disabled people adjust to each other in the common market place.

There are many economic, social and moral reasons for all of us concerned with the rehabilitation of disabled people to look forward to the next years with confidence in our mission, our leadership and our program capabilities.

We can and will be doing more to enable people with impairments to assume their legitimate role in society as fully participating citizens.

Mrs. Arneson is Director, Legislation, Regulations, and Congressional Relations, RSA.

Interview

Continued from page 20

purchasers, providers, and consumers on an ongoing basis.

Q: *I cannot help but ask, since CARF evaluates the facilities, do the facilities get a chance to evaluate CARF?*

A: Yes they do. Last year we established a formalized feedback

system for surveyed facilities that seeks out their reaction to the accreditation process. I can tell you that facilities have been most forthright in telling us exactly what they think. The answer to one question particularly stands out in my mind. We asked facilities whether they feel their participation in the accreditation process resulted in improving the quality of services to disabled people. With a response rate to the overall questionnaire exceeding 90 percent# a total of 98 percent answered, yes!

Q: *What do you see as the major changes that have taken place in facilities?*

A: Certainly two that I would immediately mention. The first is a noticeable improvement in the efficiency of their operations, and a growing movement centered around a sense of results. The second is a diversification of disabilities served, and the viability of the rehabilitation model to meaningfully respond to a broader service population.

Q: *There are many challenges confronting rehabilitation in the 80's; what challenges do you see facing CARF?*

A: In the last analysis, the major challenges confronting the Commission are not dissimilar to those of the facilities and the rehabilitation movement as a whole. We will all be required to clearly articulate and demonstrate our value to society and the effectiveness of our efforts. We must successfully compete for a level of programmatic and financial support that is ultimately responsive to the needs and expectations of disabled people.

Expanding Lebanon's Rehabilitation Programs

Joseph LaRocca, Michael Dolnick, and William Lamprell

Following the recent civil strife in Lebanon, many Lebanese were seriously wounded and there has been a marked increase in the number of citizens who are disabled and in need of rehabilitation services. The number of facilities available to care for and treat the casualties has been sharply reduced either as a result of war damage to premises, loss of professional and maintenance personnel, or through loss of funding previously received for support of services.

The U.S. Agency for International Development (AID), at the request of the government of Lebanon sponsored a team of three rehabilitation technical advisors to visit Lebanon in July-August 1979 to evaluate the existing rehabilitation effort and to "provide the government of Lebanon with the basic information needed to formulate a policy and program for the vocational rehabilitation of the handicapped, and most importantly those disabled from the war." The team of Joseph LaRocca, Michael Dolnick, and William Lamprell (the authors) worked closely with three Lebanese experts designated by the Minister of Labour and Social Affairs as counterparts to the technical advisory team. Dr. Ramez Aouad, Dr. Hicham Bāroudi, and Mr. Nadeem Schweiry singly (and sometimes

together) accompanied the AID team on the visits to the various rehabilitation facilities and to the meetings with government officials during the data collection phase of our consultation.

Beirut, the capital of Lebanon, where the bulk of our time was spent, is a badly damaged city. The consultants who recalled previous visits to this city formerly known as the Paris of the Middle East were saddened to see the large areas no longer inhabitable because of shellfire damage and the complete breakdown in communications and commerce between sectors under the control of various combatting military and militia factions.

The site visits and data collection interviews had some unusual or unaccustomed aspects not normally encountered in similar consultations in the U.S. On one visit we were required to travel with an assigned bodyguard, and bodyguards were present during some of the interviews with government officials. Our vehicles were frequently stopped at numerous checkpoints for interrogation by various armed groups. It was estimated that during this period there were over 40 different military or self designated armed militia factions operating checkpoints. With no central governmental military unit in complete control, each checkpoint

presented a potential risk of harassment or even confiscation of the vehicle.

Travel to the rehabilitation centers was either by embassy-assigned automobiles or taxicabs designated as "safe" by embassy security personnel. Because of time constraints, we frequently made our own arrangements for taxi hire which entailed considerable negotiation since a Moslem driver was usually unwilling to enter an area controlled by Christian militia and vice versa. Unfortunately, due to the unstable conditions and sporadic military action in the South of Lebanon, we were not permitted to visit that area which all experts agreed was a priority area for the development of a new center.

Although we were confined to a relatively small, so-called "safe" area, we nevertheless had the experience of being within 20 feet of the dynamiting of an official's automobile, witnessing the exchange of machine gun fire between contending militia groups, and being caught in a monumental traffic jam that prevented a victim of gunfire from reaching medical assistance in time.

In spite of these conditions, it is believed that a practical and sound plan for the expansion of rehabilitation services was developed. Implementation of the consultants' 23

recommendations can be accomplished in stages, depending on the stabilization of the country and the progress made in solving Lebanon's many internal political and economic problems.

Cultural differences have to be considered when planning for the expansion of rehabilitation services in another country and consultants must be wary of making recommendations that attempt to impose U.S. standards and attitudes that may not be suitable nor acceptable.

In much of Lebanon, the attitude prevails that a handicapping condition is God's will and, thus, self sufficiency is discouraged. The award of compensation for the rest of one's life is an acceptable solution and no further effort at rehabilitation is necessary. Many families feel that, once a referral is made to a rehabilitation facility and the person is accepted for service, the family responsibility ends. The director of an outstanding facility for the mentally ill informed us that they had to establish a rule that families must accept patients on week-ends and the necessary drugs are provided by the family because the families would not take care of this need. Several American trained professional staff commented that they believe the centers foster dependency by keeping clients too long. There were also comments to the effect that the reluctance to accept supervision or direction from women created problems for professional staff.

However, it should be emphasized that families do accept responsibility for severely disabled family members who live at home. In spite of the great problem of accessibility throughout the country, disabled people in wheelchairs living in upper floors manage because some member of the 24 extended family is usually available

for any type of assistance. It is contended by some Lebanese that the reason that suicides among paraplegics is rare is because of the strong family connections and support given in Lebanon.

In this short an article, only a few of the more significant recommendations can be highlighted. These include:

- The training of personnel in professional disciplines, including speech therapy, vocational evaluation, facility administration, and occupational therapy. This would include both long and short term training in Lebanon and abroad and scholarships and refresher courses for current professional personnel.

- The expansion of services to disability groups currently not being adequately served. Included would be people disabled by cardiovascular disorders and cerebral palsy.

- The development of two new centers in the South of Lebanon and the Bakaa valley. Satellite centers emanating from the six major existing centers should also be developed.

- An increase in the number of vocational training programs combined with a system of vocational evaluation in each rehabilitation center. Vocational evaluation as a discipline is unknown in Lebanon.

- The development of a realistic vocational skills training program modeled along the lines of the U.S. Projects With Industry program. This would include the appointment of a national industrial advisory council composed of employers, labor leaders, and chairmen of industrial councils or organizations.

- A program of architectural barrier removal, affirmative action in employment, and the elimination of discriminatory practices.

- The development, on a demonstration basis, of a few sheltered

workshops to serve those so severely disabled that competitive employment is not feasible in the near future.

- Legislation to provide a government "set aside" program for the government's purchase of products and services provided by handicapped workers. A central craft outlet for the marketing of products of sheltered workshops and homebound workers should also be established.

The U.S. state-federal vocational rehabilitation system was not recommended. Rather than having a government-operated rehabilitation program, the present Lebanese system, wherein the private rehabilitation facilities deliver the rehabilitation services with government support, seems best suited to Lebanon's structure. There is a great need, however, for the government to increase the amount paid to the centers for the services provided. Present payments cover a small fraction of actual costs. Further, there is a great need for the government to provide direct grants to the rehabilitation facilities to cover the start-up and initial costs for expansion into new areas of rehabilitation and in serving new groups of disabled people.

Fortunately, in one rehabilitation specialty, prosthetics and orthotics, Lebanon will soon experience no shortage. The prosthetics training program, supported by AID funds at the El Kafa'at Rehabilitation Center,* will be capable of providing continuous followup care to the current

*El Kafa'at means "Abilities" in Arabic and was inspired by Henry Viscardi of Abilities, Inc. A bronze Arabic inscription at the entrance is from the Bible and translates, "The stone which was rejected by the builders has become the cornerstone."



A wing of the El Kafa'at Rehabilitation Center where the authors visited an AID-supported prosthetics training program. The Center is capable of providing prosthetics services to the country's population, including followup services.

700 amputees, plus providing initial and followup services to all new amputees and people with other functional loss resulting from accidents, disease, or congenital conditions.

As a first step, the consultants recommended that AID sponsor a 20- to 30-day visit to the U.S. of a team or teams consisting of government officials and professional leaders who have or will have key roles in the rehabilitation movement in Lebanon. An intensive observation and discussion program covering all aspects of rehabilitation—service delivery; training of professionals; vocational training; placement of handicapped persons in industry, agriculture, self employment, and in sheltered

workshops; education of handicapped children and adults; rehabilitation research; and overall rehabilitation planning and programming could be set up for the team or teams in selected U.S. cities. There would be the opportunity to observe the comprehensive team approach in rehabilitation, projects with industry, the rehabilitation of cardiac and stroke patients, and operation of sheltered workshops (including the government purchase of workshop products).

The most critical need in Lebanon at this time is for short and long term training in various rehabilitation fields. After the team visits to the U.S., further short and long term training in the areas discussed in the

consultants' report can be planned.

Lebanon has a solid legislative, structural, and facility base upon which to build an expanded comprehensive rehabilitation service that can meet the needs of all its handicapped people. It is our opinion that in many respects the staff and services provided in the facilities visited were equal to and, in some instances, exceed similar programs in the United States. We were impressed by the deep personal and professional commitment in government and in the private sector to rehabilitation and its extended application in Lebanon. Future planning should capitalize on this commitment and on the interest and capacity of the private facilities to assume an expanded and principal role in a comprehensive and nationwide rehabilitation program.

As of this writing, AID and the Lebanese Government are considering the consultants' recommendations. And the visit of the first team of government officials and rehabilitation professionals to the U.S. is tentatively scheduled for the Summer of 1980. In cooperation with Lebanese officials and, taking into account the military and political situation in the country, a step by step implementation of these recommendations should follow. In any event, a blueprint now exists for an overall long range plan for the improvement of rehabilitation services to handicapped people in Lebanon.

Mr. LaRocca was formerly director of RSA's international programs and is now a consultant on rehabilitation to the Urban Institute and other organizations. Mr. Dolnick is a consultant in the Division of Rehabilitation Facilities, RSA. Mr. Lamprell is Assistant Director for Vocational Services, Maryland Rehabilitation Center.

The View From The Transmitter

Thomas Brubeck

It is nighttime, and only a few squares of yellow can be seen from the houses scattered among the trees of the small, Pennsylvania village of West Fairfield.

One of the lighted windows is the dining room of the Cauffield's old brick house, where their daughter, Margaret, is operating a shortwave radio.

This was in the 1950s, and radio was her window on the world. By this means she talked with other ham operators from Pittsburgh to Wilmington and Washington.

Twenty-three years later, the woman known as "W3UTR"—or Meg—is living in a coop apartment in Washington, D.C. When she is not fine-tuning her transmitter or tooling around in her white and burgundy Volare, she is at her typewriter in the Switzer building, working as a secretary for the Rehabilitation Services Administration.

Meg Cauffield has more than a feel for the agency's mission. She has had osteogenesis imperfecta (brittle bones) since the age of 2, has never weighed more than 57 pounds, has spent her life in a wheelchair, and, until she was 34 years old, lived the life of a shut-in.

She was born on a farm in western Pennsylvania, where both sets of grandparents lived, and she moved to West Fairfield when she was 14. Meg began experiencing fractures as an infant and has not walked since she was 26 3 years old.



Being homebound as a child, Meg made use of books which her younger brother, Paul, brought home from school. With the help of her parents, she was able to receive this early, bootleg learning. She passed 8th grade tests, and that was it for "formal" education.

She was away from other aspects of life as well. "I had so little social experience at home—just shopping trips and visiting relatives. I was not out of the state of Pennsylvania until 1950, when I visited my brother in Schenectady. That trip is large in my

memory."

Their minister from the Presbyterian church is the one who pushed the button. He stopped by at the house and talked amateur radio to Meg. They began studying theory and memorizing the Morse code. For awhile, she was so attuned to the dit-dah rhythm of Morse code, she could hear it in a bird's song.

Soon, Meg bought by mail a second-hand, homemade transmitter for \$30, plus a receiver for \$40. The collection of tubes and wire which sat exposed on a small, metal chassis brought her out to the world. Two years later, in 1954, she graduated to a phone set. Day and night, she had "QSOs" with people throughout the United States and sometimes overseas.

"Radio let me be on the same level as other people. It had nothing to do with physical attributes," said Meg, who looks tiny in her wheelchair. "I was a noise, a personality, a mind. I was able to meet people on a more equal basis."

It was through one of her radio contacts—Barbara Houston of Forest Heights, Maryland—that she was invited to visit the Washington D.C. area. It was her first trip away from her family. There was sight-seeing, and she met some handicapped people, who mentioned the possibility of getting a job with government.

In 1956, a rehabilitation counselor in Pennsylvania asked Meg if she

would be interested in receiving training at the Woodrow Wilson Rehabilitation Center in Fishersville, Virginia. She immediately went for the idea, but some officials at state headquarters in Harrisburg had some doubts about Meg's potential. They drove up to West Fairfield to talk with her.

Meg was accepted. She went to Fishersville in 1956 and stayed for 15 months. While there, the center was visited by the late Mary Switzer and others from the Office of Vocational Rehabilitation, a predecessor agency to the Rehabilitation Services Administration. One of them told Meg how to get on the civil service register.

Meg returned to Pennsylvania for a short time. On a memorable day—January 21, 1958—she started work in Washington for OVR.

"My mother, an uncle, a cousin, and I left home at 4 a.m. on a bad day," she said. "It was snowy and icy and we drove on a narrow road over Johnstown Mountain. We should have taken the turnpike. But as we drove into Washington, the sun was shining and it was very impressive."

Members of the Young Ladies Amateur Radio Club located an apartment for Meg, who was now living independently. She found the first winter quite lonely after the protective environment of Fishersville.

"The biggest problem was transportation. I had to use taxi cabs, and my \$94 take-home pay every two weeks did not leave much for cabs. I shared the expense with another girl in a wheelchair, but the system was not reliable."

Less than a month after starting work as a clerk-typist, she caught a severe cold while waiting for a taxi, sitting for a long period in a cold lobby.

"I was ready to quit and return home," she said. "I was desperate. I

put a notice in an employee newsletter that I would pay someone to drive me to work. That's when the Department realized the problem and began issuing parking permits to those who drive handicapped people. That solved my transportation problem."

Later, she did more bartering. Her new apartment entitled her to a parking space. She didn't have a car at the time, and learning to drive had not even occurred to her. She traded her parking space for trips to the grocery store.

"I do have problems, but I have opportunities to solve them," said Meg. "Since I don't have family here, I had to learn how to cope and to ask for help when it is needed. I recommend that handicapped people get out on their own when they can."

The latest step to being on her own was learning to drive a car, which is equipped with hand controls.

"It was one of the hardest things, physically, I've learned to do," she said. "I spent about \$500 on lessons. One of the persons who had confidence in me was Laurie Bean, who put me behind the wheel of Bill's car to try it out and helped me shop for a car. Another person who encouraged me said that I should learn to drive because I have my own agenda."

But some of Meg's acquaintances did not believe she should drive.

"Some people have suggested that I might cause a serious accident," and that is the sort of thing that sticks with you." She hesitated for a moment, her blue-grey eyes looking puzzled. She added, "Handicapped people are not all that different from normal people."

Four years ago, Meg initiated and helped organize a local group of people who are affected by woi, and she has edited its newsletter.

She was named Outstanding Adult With O.I. of 1978 by the American

Brittle Bone Society. She also has been recognized by her employers in RSA for sustaining a superior level of work performance.

Sometimes on weekends, Meg and her wheelchair can be seen among the documents of the National Archives, where she is digging into family history. She has been working at the genealogy project for the past year.

Meg Cauffield is a severely disabled person who is making her own history. As friends could vouch, there's more there than meets the eye.

Mr. Brubeck is Acting Director, Public Affairs Staff, RSA; Editor, rehabilitation section, *Human Development News*, Office of Human Development Services, HEW.

IYDP

(Continued from page 12.)

organization, and each federal, state, and local government agency to participate in the year on behalf of those disabled people in their community, city, or state. The success of the year is dependent in large measure on the involvement of people who work through state agencies, civic and community groups—of officials at all levels of government—and of workers and management in business and industry—all undertaking activities to heighten awareness of the capabilities of disabled people and of their needs for integration in society.

For further information on the activities of the committee, to communicate your thoughts about the year, or to inquire as to how you may participate in the year, write to Dr. Robert A. Leyton, Director, Federal Secretariat, International Year of Disabled Persons, 330 C Street, S.W., Room 3118, Washington, D.C. 20210. Or phone (202) 245-3498.

Language Used or Used Language?

Obfuscation is a term that defines the art of utilization of many big words on the pretext that these words are a modicum of itself to them and a new world in which we live. No, it's not true!

In Politics: A forthright statement of conviction about almost anything must be calculated to draw, at minimum, irritation from at least one group, if not overt hostility from another. This reality, it seems, did not as much bother politicians of old as it does their modern day counterparts. In a *Washington Star* article, "The Language of Politics," Rod Mac Leish quotes Samuel Eliot Morrison's comment about the Lincoln-Douglas debates: "for keen give and take, crisp, sinewy language and clear exposition of ideas." But, of the counterpart, Mac Leish offers that "Professional speech writers are hired to render candidates' thoughts into a tepid, inoffensive mush; the object is not to inform but to tranquilize as many of the people as much of the time as possible."

Jeff Mac Nelly, the syndicated cartoonist of "Shoe," in a social comment about this phenomenon has Shoe and another reporter listening to the blandishments of Battson D. Belfry who is running for President. As the *non sequiturs* flow from the stump, Shoe's friend asks what Belfry is talking about. Shoe: "Listen Pal . . . It's hard enough reporting about what he *says* without getting into what he *means* . . ."

In another *Star* article by Arn Tibbetts, the author describes

keep control of the people by denying them a sense of reality." In the political arena, Tibbetts tells us about George Orwell's 1984 character, O'Brien, who is the party philosopher and torturer. He quotes O'Brien as saying, "Whatever the party holds to be truth is truth," but, tongue-in-cheek, Tibbetts tells us that O'Brien might have put it thusly in newspeak: "Hopefully, reality concepts function in terms of party ideology acceptability." In not assigning this fuzzy terminology to O'Brien, Orwell missed making perfect the prophecy of 1984!

Superabundance. (Sue these words for nonsupport.)

Participate *actively*. There is abundant activity in participate so that its use here adds nothing to participate. If it is a matter of passive participation, then, fine, hook up the adverb to its verb. But even passive participation implies some activity.

Prior experience. Experience assumes the past, so, unless you want to express a past action or occasion that happened before another past action, the word itself expresses "an accumulation of experience to date" without further adornment.

" . . . that may have become rigid *with time*." What a fantastic word is the verb! It has *mood* that expresses fact, existence, command. It has *tense*

that tells time. It has *number* that indicates singular and plural. It has *person* that lets us know who is doing what. The verb's tense, in the above fragment, tells us amply of the possibility that rigidity had taken place. The author wasted *our time* with what is a repetition.

Pastiche. (Grab bags are great in junk sales; they have no place in precise writing.)

In her *Washington Post* department, "Pastiche," Judith Martin comments on the many thousands of complaints received by the Federal Communications Commission about church loudspeakers that suddenly announce not-too-gentle truck driver messages, toasters that express opinions not necessarily their own, and long hair music lovers who discover their Beethoven accompanied by lyrics. Of course, the butt of her remarks refer to the electronic communications.

She muses that the time may be at hand to develop a new mode of communication. The following quote is her idea on the subject: "Supposing you have something personal to say to a friend. If there were some way you could put it on a piece of paper, seal it, have it physically conveyed to the address, and allow that individual to read in solitude, it would accomplish the task.

"It would not be easy to get such a system into operation. First of all, school children would have to be taught to write and also to read, which might seriously interfere with the development of their filmmaking skills. Then the government . . . would have to find a way to transport these communications . . .

"It would require daring, imagination, and perseverance but, considering the modern record for bringing convenience and frustration within the reach of every citizen, perhaps it could be done."

An Analysis Of Post Employment Service

Joseph Abrams

The primary objective of the vocational rehabilitation program under the Rehabilitation Act of 1973 is employment, not just for 60 days (at which time a counselor may report the person rehabilitated), but sustained employment and at a satisfactory level. For people financed for rehabilitation under the Social Security Disability Insurance/Supplemental Security Income-VR programs, this employment is a substantial gainful activity earnings-level which is understood to mean to terminate benefits and, consequently, provide a savings to the Social Security Trust Fund or Supplemental Security Income Fund. The purpose of post-employment services (PES), which are administered following rehabilitation closure, is to help maintain long term employment.

Post-Employment Services

PES as a followup to help maintain employment after rehabilitation closure were first authorized by the 1968 Amendments to the Vocational Rehabilitation Act (P.L. 90-391). The Rehabilitation Act of 1973 broadened the PES concept. Post-employment services is the inclusive term for all services provided after clients have been determined to be rehabilitated, without distinction or definitions for followup, follow-along, and other post-employment services.

PES may include any vocational rehabilitation service or combination of services necessary to assist the person in maintaining employment if the service (or several services) does not entail a complex or comprehensive rehabilitation effort unrelated to the original individualized written rehabilitation program. Counseling and guidance are as essential during the PES period as they are during other phases of the vocational rehabilitation process and constitute the core service by the counselor around which all other PES are provided.

1978 PES Study

A Rehabilitation Services Administration (RSA) national review of state VR agency use of PES was conducted by RSA Regional Offices using methods adapted from material submitted by JWK International Corporation, Inc., in 1977.

The objectives of the study were to:

- Assess the implementation and application of instructions and the manner in which the services are being provided;
- Identify areas of strength and weakness in administration of PES;
- Assist state VR agencies, through consultation and technical assistance based upon findings of this study, to improve their practices in the provision of post-employment services;
- Secure information for program

planning, improve and refine national guidelines, and chart the direction of future state and national activities and efforts in the area of PES.

Ten state agencies participated in this review, one in each federal region. Each RSA regional office was responsible for the review in their respective state agency of the written policy and procedural instructions for comparison with federal requirements, interviews with key state agency staff on the organization and provision of PES, and a sample review of PES cases which included rating the quality of services provided. Each RSA regional office also compiled data and submitted a report both to the state agency and RSA Central Office.

RSA Central Office was responsible for the design and issuance of the study plan and instructions, technical assistance to the regions, and the preparation of a national report which was a collaborative effort¹ coordinated by Dr. Richard Melia of RSA. The full national study report, including findings and recommendations, is provided under RSA Information Memorandum 80-15, dated February 8, 1980. The following material is essentially a reprint of the analysis portion of the study.

PES Experience

Although PES in their current broadened form have been in existence as a consequence of the Rehabilitation Act of 1973 and most state VR agencies have written procedures for providing PES, only an insignificantly small number of rehabilitants have received these services.² The PES study reveals, however, that PES are beneficial to those who receive them. This is demonstrated, for example, by documented examples, as contained in an RSA Information Memorandum;³ post-rehabilitation closure 29

Table 1

Outcome of Post-Employment Services in Closed PES Cases
for Clients Served under the Basic Program
(Percent of cases Closed by Agency and Reason for Closure)

Reason for Closure ¹	Conn.	N.J.	Penn.	N.C.	Ohio	Texas	Mo.	S.D.	Ariz.	Ore.	Totals	%
Problem Solved	57	63	96	63	80	37	85	73	43	46	157	64
Independent Level of Functioning Attained	17	7	—	50	68	33	41	53	50	33	84	34
Employment Continued at a Suitable Level	4	7	—	63	40	4	11	43	32	38	44	18
Condition Got Worse and PES could Not Help	17	13	—	—	—	—	4	10	7	8	16	6
Case was Reopened	4	7	—	—	8	—	15	10	7	4	15	6
Other	—	3	4	50	20	8	4	13	25	38	33	13
Number of Cases Closed	23	30	24	8	25	24	27	30	28	24	243	100
Percent of Closed PES Cases with IWRP Goal Not Met	57	33	—	50	12	17	—	17	46	33	60	25
(all cases) n =	31	42	30	33	42	30	34	40	32	30	331	100

¹ Percents based on actual number of closed cases. Results are not additive as reasons for closure are not mutually exclusive.

Table 2

Outcome of Post-Employment Services in Closed PES Cases
for SSDI and SSI Funded Cases
(Percent of cases Closed by Agency and Reason for Closure)

Reason for Closure ¹	Conn.	N.J.	Penn.	N.C.	Ohio	Texas	Mo.	S.D.	Ariz.	Ore.	Totals	%
Problem Solved ²	50	50	100	56	71	92	—	75	80	100	58	81
Independent Level of Functioning Attained ³	—	—	—	22	43	25	—	50	33	83	30	42
Employment Continued at a Suitable Level ⁴	—	—	—	56	57	42	—	50	40	72	35	49
Condition Got Worse and PES could Not Help ⁵	—	—	—	22	—	—	—	50	—	11	6	8
Case was Reopened	—	—	—	11	—	—	100	50	—	6	5	7
Other	—	—	—	11	—	—	—	25	—	—	2	3
Number of Cases Closed	1	2	2	9	7	12	1	4	15	18	71	100
Percent of Closed PES Cases with IWRP Goal Not Met ⁶	0	100	0	77	0	0	0	0	60	100	36	33
(all cases) n =	2	6	2	17	8	20	2	5	22	22	106	100

¹ Percents based on actual number of closed cases. Results are not additive as reasons for closure are not mutually exclusive.

² through ⁶ refer also to levels of employment commensurate with SGA and selection criteria.

Table 3

Year	1971 VR Closures For Whom There is SS Match	No. With Earnings	Percent with Earnings	Mean Earnings for the Year	Total Earnings for the Year ¹	Purchased Services Cost only ²
1972	228,666	152,002	66.9	\$3,786.6	\$574,958,611	\$153,979,542
1973	228,666	148,525	65.0	4,372.0	649,349,532	153,979,542
1974	228,666	142,020	62.1	4,965.9	705,253,593	153,979,542
1975	228,666	131,842	57.7	5,363.1	707,080,288	153,979,542

¹ Total earnings for the year of VR Closure (1971) were \$517,832,745. The total earnings for the year before referral to VR were \$350,550,160.

² Applies to all rehabilitation closures in 1971.

problems usually solved by PES and employment continued at a suitable level (see Tables 1 and 2); and the high rate of PES clients maintained in competitive employment.

Post-Rehabilitation Earnings

Earnings reported under Social Security requirements from 1972 through 1975 on all vocational rehabilitation closures in 1971 have been collected under the "RSA-SSA Data Link System" and selected data are shown in Table 3.

Notation should be made that for the years depicted in Table 3, PES had no substantial impact, particularly in the years before 1974. The table also shows that, for those closed from VR in 1971, there has been a decrease in the percent of those with earnings from 67 percent in 1972 to 58 percent in 1975. The challenge to the rehabilitation programs is for PES to raise the percent of rehabilitants with earnings and the amount of earnings for a longer period.

Average Cost of Rehab vs. PES

The average cost for PES is reflected very favorably when compared to the cost of initial services per rehabilitation as shown in Table 4. By contrast to the rehabilitation costs, the total PES cost for 8,059 Section 110 (basic support) clients in FY 1978

Table 4

Year	Average Cost Per Rehabilitation ¹			Total Cost of 110 Rehabilitations
	110	Trust Fund	SSI Fund	
1977	\$3,502	\$7,589	\$6,565	\$965 million
1978	3,584	7,882	6,994	\$986 million
Total	\$7,086	\$15,471	\$13,559	\$1.9 million

¹ It takes 2 years, on the average, to attain a rehabilitation (and under an average of one year to complete initial PES program.). Accordingly, data is shown for a 2-year period, FY 1977-78.

was \$2,099,497, or an average PES cost of \$261 in that year.

A review of the preceding data in this analysis suggests that the expenditure of funds for needed PES is a good investment for a relatively small cost. . It protects and strengthens the value of the initial VR services by resolving employment problems and extending the period of employment.

Post-employment services have a very beneficial outcome in keeping rehabilitated clients on the job, but are currently being provided in a relatively small number of cases. When Congress added the PES feature to the Rehabilitation Act, funds were not specifically earmarked for PES. The cost of post-closure client contacts, as well as direct post-closure services costs, was left to compete with (and reduce in direct proportion) the available funds for

services to achieve initial rehabilitation, that is, Section 110 expenditures.

An issue we now face is whether to budget specifically for post-employment services. This is possible at the state level, where some of the funds available for the basic program (Section 110 funds) could be reserved in a special fund for PES. Such action, however, would not solve the problem of PES funds competing with or reducing funds available for initial rehabilitations. Therefore, budgeting priorities and presentation questions must be addressed at the federal and state levels. At the federal level, presentations for the executive budget and Congress should clearly present the benefits and costs involved in PES, indicating the consequent effect of cutbacks in services—initially or at the post-closure state if additional funds are not provided. 31

The option of providing specific funds for PES could be considered.

Further work should be undertaken to analyze the cost-benefit factors related to PES. Post-employment services could be expected to at least offset the cost of additional rehabilitation services which would otherwise occur; protect the value of the initial services; or effect a combination of the two. The RSA-SSA Data Link might be modified to track the length and value of employment of people who are provided PES.

PES needs to be upgraded and given higher priority, both federally and in the states. Issues for consideration include:

- *The need of state agencies and VR counselors for additional resources to carry out effective PES.* This means either extracting funds from initial rehabilitation services or providing additional resources or a combination of both.

- *The need to define quality outcome in terms of post-rehabilitation activities and continuing employment.* This includes:

- a concern for keeping the rehabilitant in employment for a specific, minimum period (e.g., 9-months, 1 year, or longer) beyond closure as rehabilitated (status 26). This period should be given similar significance to that given to 60-days employment, prior to claiming a rehabilitation.

- a goal to be set for average length of employment following rehabilitation, e.g., at least 3 to 5 years. Justification for a minimum length of employment and goals for extended employment becomes obvious when one considers that, unless meaningful employment is continued, the whole matter of usefulness of services leading to rehabilitation is laid open to question.

- a procedure under which the VR counselor is given specific credit

for post-employment services production and accomplishments. These services must become a *routine* part of the job on an equal footing with initial rehabilitation services.

- model methods of PES delivery and use of PES specialists, such as assigning paraprofessionals to carry out routine PES client contacts and related PES activities and assigning PES activities to the counselor who provided the initial VR services or to a special counselor. By such specialization, this activity will be assured, and the temptation to reopen the case to provide another course of rehabilitation services will be reduced or eliminated.

- state agency and federal reports which more fully reflect PES activity and routinely reflect the length of time employment has continued as a result of VR services (which may or may not include PES). Additional status codes are needed to distinguish whether a person is simply eligible for PES, receiving or has completed such services (successfully or unsuccessfully), and the number of PES programs completed.

- *The need for adequate provision for monitoring, evaluation, and quality assurance activities.* Such activities can assist in determining cost benefit effectiveness of PES, including tracking of PES provided and the length and value of employment. Quality assurance systems in the state agencies can be employed to assure adequate PES case management and provision of efficient and effective PES, to reduce costs, and to assure the use of similar benefits and other resources.

- *The need for further studies and pilot projects to evaluate the extent to which PES are needed and how to carry them out efficiently and effectively.* Further studies would assist, for example, to determine

when and to what extent PES services are needed (this can be done by a review of rehabilitated cases in which no PES were provided) and to identify different methods for PES being used by the state agencies and those which prove most effective.

Pilot projects would be useful, for example, to test specific procedures for PES and different times of application of those procedures to ascertain the most propitious time, type, and extent to which PES are needed, the use and effectiveness of paraprofessionals and special counselors in providing PES, and when to use PES and when to reopen a case for a new or subsequent program of rehabilitation services.

Mr. Abrams is RSA senior staff specialist on the SSDI/SSI-VR Program. He is co-author, with Richard Melia, Ph.D., of RSA of the PES study commented on.

Notes and References

(1) Joseph Abrams was responsible for all RSA Central Office aspects of the study relating to SSDI/SSI-VR operations as well as preparing the national report in conjunction with Dr. Richard Melia and others.

(2) RSA Information Memorandum 78-59, indicates that nationally, 7,680 post-employment cases available in FY 1977 represented only 2.5 percent of the 303,328 cases rehabilitated in FY 1976. RSA IM-79-43 indicates that nationally, 9,792 post employment cases available in FY 1978 represented only 3.4 percent of the 291,202 cases rehabilitated in FY 1977. While the data for FY 1978 reflect a considerable increase over the preceding year, post-employment cases remain a minuscule proportion of rehabilitated cases.

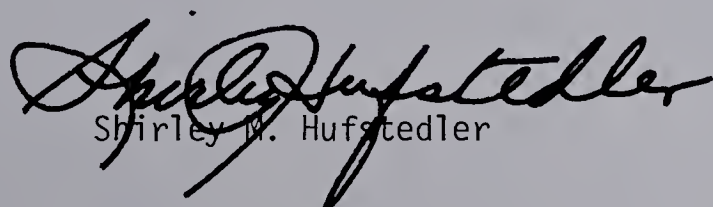
(3) IM-80-15, dated February 8, 1980, RSA.

THE SECRETARY OF EDUCATION
WASHINGTON, D.C. 20202

As the first Secretary of Education, I am pleased both to welcome the Rehabilitation Services Administration to the new Department of Education and to pay tribute to this outstanding program on the sixtieth anniversary of its creation.

The vocational rehabilitation program is widely recognized for its work in helping handicapped people find gainful employment and lead independent lives. Through the almost Herculean efforts of disabled people themselves, and of the many professionals who are dedicated to their cause, American society has been immeasurably enriched since 1920 by the fuller participation of millions of handicapped citizens in our national life.

I am confident that this excellent record will be maintained and strengthened over the coming years. The new Office of Special Education and Rehabilitative Services in our Department will enhance the vocational rehabilitation program by building bridges to other disciplines concerned with disability. The Civil Rights provisions of Title V of the Rehabilitation Act of 1973 will increasingly open new avenues of opportunity for handicapped individuals. I believe that the people of our nation will make great progress in overcoming attitudinal barriers and will demonstrate new sensitivity and maturity towards disability and disabled people.



Shirley M. Hufstедler

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MARCH-APRIL 1981

AMERICAN REHABILITATION



DORSEY: Symbol of Urban Deaf Condition
See Page 3

THE WHITE HOUSE

WASHINGTON

International Year of Disabled Persons, 1981

We seek, in the 1980s, an era of national renewal, an era that will set loose again the energy and ingenuity of the American people.

Today there are 35 million disabled Americans who represent one of our most under-utilized national resources. Their will, their spirit, and their hearts are not impaired, despite their limitations. All of us stand to gain when those who are disabled share in America's opportunities.

To increase the participation of disabled persons in our national life and in the lives of other nations, the United Nations has designated 1981 the International Year of Disabled Persons. America has long been a world leader in this area, and the United States Council for the International Year of Disabled Persons and our Federal Government have already responded to the United Nations challenge. Programs are underway throughout the Nation.

Through partnerships of disabled and nondisabled persons; of our private sector and our government; and of our national, state, and community organizations, we can expand the opportunities for disabled Americans to make a fuller contribution to our national life. I am proud to pledge the cooperation of my Administration and the Federal agencies under my jurisdiction, including the Federal Interagency Committee for the International Year of Disabled Persons.

Ronald Reagan

AMERICAN REHABILITATION

Volume 6, Number 4

The weakest ink is better than the strongest memory.

March-April 1981

3 Dorsey: Symbol of Urban Deaf Condition

McCay Vernon, Ph.D.,
and Carolyn Hyatt

7 Review: Annual Review of Rehabilitation

Christopher Wood

9 Client Motivation And Responsibility

Jack M. Richman, Ph.D.,
and Sol Richman

19 Administrative Strategies In
Rehabilitation: Retrenchment Or
Stability?

Gerald K. Wells, Ph.D.,
Laura A. Edwards, and
David R. Ziskind

25 Where Disabled People Live As One Family

Thomas Brubeck

DEPARTMENTS

2 Topic of State

12 New Publications

14 Notes On The Margin

18 Access America

23 International Year

24 Language Used

29 Report Resources

30 News, Notes, Announcements

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TOPIC OF STATE

Gift Shop Opened For Workshop Items

Featuring gift items for sale made by those in sheltered workshops and by homebound handicapped people, a unique Hand to Hand Shop has been opened in a 700-square-foot area off the concourse in the Governor Nelson A. Rockefeller Empire State Plaza, Albany, New York. Plans call for three more Hand to Hand shops in the next few years at Buffalo, New York City, and Rochester.

The new shop gives "a good exposure to what handicapped people can do," according to store manager Mrs. Ruth B. Walsh. Walsh explained that many fine gift-type products made by handicapped people have long gone unmarketed for lack of adequate financing or an appropriate retail outlet store.

—*The New York State OVR Sun*

Program Focus: Rehabilitation Engineering

The Rehabilitation Engineering Section is a relative newcomer to the California Department of Rehabilitation, having been established about 3 years ago. Under Chief Tom Burns, the section serves as a clearing house for rehabilitation engineering technology and as a resource to counselors on assistive devices.

The section has staff in the Central Office in Sacramento and at Rancho Los Amigos Hospital in Downey. Consultation and information on 2 rehabilitation engineering are avail-

able at both locations. In addition, the Rancho Office has equipment to allow actual try outs of various devices, wheelchairs, and vehicle modifications.

In the past, section staff have provided direct services to counselors, giving evaluations and design of special equipment. Now, with the help of section staff, capability of delivery of rehab engineering services has been developed at U.C. Davis and Cal State University, Sacramento. By referring clients to these facilities on a fee-for-service basis, the department will be able to provide a full range of services at a minimal cost to the state. The Department of Rehabilitation engineers will continue to provide evaluation and consultation as before.

Another recent development in rehabilitation engineering is the establishment of a computer based information system which will allow anyone to retrieve information on the latest technological developments all over the country with one phone call. This system is currently being set up nationally. In connection with that, the Rehab Engineering Section is implementing a system of "information brokers" who will gather and disburse information on a local level.

—*What's Happening*, California Department of Rehabilitation.

Resource Room Supports VR Adjustment Program

Adjustment programs in vocational rehabilitation centers around South Carolina are helping physically and mentally handicapped people prepare for their entry into the world of work.

The program began in March 1978, as part of an innovation and expan-

sion grant that established an Adjustment Information Resource Laboratory to improve rehabilitation services to severely disabled people. . . .

A centralized adjustment information and resource laboratory is being operated from the State Office to supply local centers with materials for their adjustment programs. Film strips and cassettes, slide presentations, hand-on materials, booklets, pamphlets and manuals are available through the resource lab. . . .

Structured adjustment programs have been established in VR centers as well as in statewide facilities and school programs. . . .

Though the grant ended in September 1980, the program will be continued at least at a maintenance level for continuation as a part of the vocational rehabilitation program.

—*New Horizons*, South Carolina Vocational Rehabilitation Department.

Management Experience For Blind Clients

For the past six years, (Wisconsin DVR's) Business Enterprise Program (BEP) has operated concessions in Wisconsin's state parks. "As far as I know," states Dennis Wilkins of the BEP, "we're the only state blind agency operating food service in state parks. I think Canada is involved in such an effort."

The concessions generally run from Memorial to Labor Day, 7 days per week.

The operators are all young, most college students in need of summer employment. Paul Nowland, operator of the Mauthe Lake site says this past

(Continued on page 8.)

Dorsey: Symbol of the Urban Deaf Condition

McCay Vernon, Ph.D., and Carolyn Hyatt

What kind of life awaits a young deaf person who leaves school unprepared for today's highly competitive and technical world? Undereducation inevitably proves to be a major handicap in seeking employment. When the youth is deaf, the problem is compounded. Dorsey's case illustrates the problem.

Dorsey is 20 years old. His parents never married, and his mother is receiving welfare, which we euphemistically refer to as social services. Several older brothers and sisters, as well as many of their neighbors, are also on welfare. Dorsey's mother has no employment history. His father, who no longer lives in the home, is also unemployed, although he had worked sporadically in the past.

Dorsey's speech cannot be understood. He functions on an approximately third grade reading level even though he attended a public high school. Reports indicate that, like most of his deaf and many of his hearing peers in inner city schools, he cut 25 percent of his classes. Many of his teachers knew nothing about deafness. In fact, one year an itinerant minister was hired on a substitute teacher's salary to educate him. The clergyman had never seen a deaf person before. Dorsey left school as soon as he was 16, glad to escape the frustration and failure which had characterized his educational experience.

Although he has fathered a child who is getting social service money, Dorsey is unmarried. He is now going with a different woman. He tried to obtain assistance from the Department of Vocational Rehabilitation once or twice, but it never worked out. This was partly because Dorsey did not show up for his scheduled appointments. He did not fully understand the letter setting up the appointments or their potential significance for his future. Besides, the counselor he had, who could use sign language, was transferred. Dorsey's case was given to a counselor who had no other deaf clients, 250 hearing clients, and no knowledge of sign language. Dorsey could not communicate with her and felt embarrassed and humiliated.

Records indicate that the police have picked Dorsey up once for stealing and several times for fighting when drunk. Except for one night in the city jail, the authorities have always let him off because he is deaf. Although he has not done much jail time, Dorsey is into petty stealing and some fencing of "hot" goods, as are many of his hearing and deaf peers. He has used marijuana and tried other drugs, but is not addicted at this time. However, Dorsey can get you almost any kind of drug you wish. Furthermore, he can tell you where to buy all kinds of merchandise at half price. Trouble is, it is "hot."



Dorsey has worked for a few weeks, once as a dishwasher and once as a bus boy. In each case he was fired when he failed to show up for work regularly and was frequently late. Though he has no license, he can drive a car. He cannot make change. Dorsey gets Supplementary Security Income (SSI). This, along with what his mother receives from social services, enables Dorsey to eat and dress adequately.

Despite his limitations in writing and speaking, Dorsey is fluent in his version of American Sign Language (ASL). If you discuss issues with him in ASL, you find that he has a lot of knowledge. He is streetwise.

Dorsey says he wants to work, but has no real concept of what is involved in getting and keeping a job, or what jobs he could do. However, he thinks that if he obtains a job, he will be able to function exactly as he did in school, *i.e.*, show up irregularly, be late most of the time, dress as he wishes, and periodically give his boss an "elevated middle digit."

Despite these negatives, Dorsey has some important, marketable traits. He is of average range intelligence and can understand most of what is communicated to him in sign language. Dorsey also has average-to-good motor skills, is physically strong, and is motivated to earn money. He has the physical and intellectual abilities to perform many jobs at the unskilled and semi-skilled level. Given special training, he could master a number of well-paying and respected trades, *e.g.*, auto body and fender work, painter, carpenter, cook, presser, truck driver, etc.

Most of Dorsey's friends, except for his family, are deaf. The overwhelming majority of them are also unemployed. Two are in the city jail awaiting sentencing. The majority of his deaf friends get SSI money just as

he does. Several of them work periodically at car washes and in restaurants. He even knows three deaf men who have good full time jobs. One is at the post office, one is a machine operator, and the other works in construction.

In his city and throughout the United States are thousands of deaf people of whom Dorsey is symbolic. The Dorsey's of the deaf community live surrounded by welfare, inappropriate education, and a lack of adequate rehabilitation services. Dorsey's cost to society is not just SSI payments. He has a child who gets social services, and the child's mother does, too. The mother, with a young child, deafness, and no education is almost doomed to a lifetime on welfare. Before long, Dorsey will probably have other women friends and other children, most of whom will probably join the welfare rolls.

This picture is not overdrawn. Dorsey is a typical, young inner city deaf client representative of at least 30 percent of deaf vocational rehabilitation clients in major American cities.

These people have potential for rehabilitation, yet this will never be realized unless something comprehensive is done. What rehabilitation services are needed to overcome the educational, sociological, and communicative handicaps of the "Dorseys" of society?

Service Needed

Counselor Requirements—Rehabilitation specialists are needed who can use sign language fluently with Dorsey and other deaf people. Without this kind of communication, there can be no rehabilitation for Dorsey. Skill in sign language must take priority over degrees in counseling, social work, or psychology because all of that knowledge which a professional may have is denied Dorsey or

others like him if his counselor lacks sign language competence.

Sometimes an interpreter can be used, but this is an emergency measure at best. It also means that two people are being paid to do one person's job. It might be better to let the interpreter do the work under the supervision of a trained counselor. To assign Dorsey to a general counselor is to doom his rehabilitation.

Vocational Evaluation—It is necessary to find out whether or not Dorsey and the thousands of others like him in this country have enough work potential to justify rehabilitation. Most of them do. The specific skills they have must be assessed. Thus, a complete vocational evaluation by a professional skilled in sign language is a necessary first step. This may take 3 to 6 weeks and should ideally be done in a comprehensive rehabilitation facility which would enable Dorsey to try certain vocational training areas on an experimental basis.

Work and Personal Adjustment Training—A deaf person, who has grown up in a welfare environment, whose entire life has been separated from work, and whose educational experience tolerated and almost encouraged behaviors which an employer would never accept, is obviously not ready for work. Even if Dorsey had job skills, his work attitudes and habits would preclude successful employment. Thus, what is needed is an intensive, long range work adjustment program.

There are two ways to provide this. One method is to set up a special program specifically for deaf clients. This is expensive and tends not to be satisfactory because deaf clients, such as Dorsey, need to be shoulder to shoulder with hearing peers who are functioning closer to the levels demanded by competitive industry.



NOTE: The photographs on this page and on the front cover are of Dominic Speronza. Dom, unlike "Dorsey," is continuing his education. He is presently a chemistry major at Gallaudet College, and he plans to join the Peace Corps upon graduation. Photos on this page and on the cover are by Carolyn Hyatt.

Another alternative for training is to put Dorsey in comprehensive rehabilitation centers with normally hearing clients. If this is done, an interpreter must be provided for the deaf person, and other extensive support services, such as counseling, tutoring, and specialized instruction, are basic requirements. Unfortunately, currently when deaf clients are placed in such centers, the specialized support services are usually grossly insufficient. As a result, the major potential value of the training is lost.

Vocational Technical Education— A person who is at a third grade academic level needs vocational education. Unfortunately, most vocational programs ignore people like Dorsey. First he does not meet the education requirements for their vocational-technical training areas. These include standards such as an eighth to tenth grade reading level, mathematical skills including computational ability, the capacity to learn from books, and so on. Second, and more importantly, nobody really wants to bother with the Dorseys of the world and that includes most of vocational education.

However, trades, such as certain kinds of machine operation, some areas of auto repair, key punch, upholstery and furniture refinishing, carpentry, janitorial work, masonry, welding, cosmetology, painting, cooking, barbering, and a large number of similar occupations, can be mastered by Dorsey and others like him. However, instruction and testing for those who are deaf must be in sign language and involve little or no dependence on reading. The best approach may be to have a tutor-interpreter who goes to a place or industry that teaches the trade and works right there with the client.

Housing — Another major need for the Dorseys of the world is some form 5

of supervised group living for deaf adults. There are a rather large number of deaf people (and probably Dorsey would be one if his mother were not alive) who are in institutions or they are otherwise unable to work because they lack the skills required to live fully independently. If a "group housing" situation was available, these people could work and, in general, function adequately. Others could work in sheltered workshops during the day and return to the home in the evening.

This type of group home would also be available for clients who need vocational training which would require their move to a different community. Some of these potential trainees are people who are not ready to come to a large city and live alone, but who cannot get the vocational education they need at home.

Client Services Money—Government rehabilitation agencies keep talking about the high priority being placed on service to the severely disabled deaf client. These good intentions are a *tour de force* if rehabilitation counselors have only \$15,000 per year of client services money to spend for an entire case load. Under such circumstances, they would be fools to even try to serve a client such as Dorsey who obviously needs extensive, long range, and expensive services.

The real answer to the clients services money issue is the earmarking of money for the deaf and the specialization of counselors to work with deaf clients in a way analogous to that which is now done with blind clients.

Sheltered Workshops—There is a significant number of multiply handicapped deaf clients who will never be able to work competitively or who need lengthy job experience first. A sheltered workshop located near the group home would meet this kind of

Education—Dorsey and the thousands of other deaf clients of whom he is representative have failed and have been failed by the educational system for 10 or 12 years of their young lives. At this stage in their development, it is totally unrealistic to assume that many of them can be taught to read, or do math at a bonafide high school level. However, they desperately need basic survival skills, information about a balanced diet, help with birth control, budgeting for daily living, getting assistance on income taxes, and obtaining a driver's license. The driver's license greatly enhances mobility; therefore, employability. Preparing people like Dorsey for passing the written form of the driver's license examination is a specialized, difficult task. These kinds of skills might be taught in adult basic education classes for deaf people at a local high school or college, if the instructor were skilled in sign language and knowledgeable about deafness.

Job Placement—In contrast to Dorsey, Edith V. has a masters degree in microbiology, a record of publications in her field, and 20 years of laboratory work experience. Yet, because she is deaf, even she needs an interpreter when she goes on a job interview. Dorsey and clients with his limitations cannot read the classified adds or fill out a job application intelligently. More importantly they lack the extensive "grapevine" most of us have to locate jobs because all their friends are deaf and their family and most friends are on welfare.

To send Dorsey down to the U.S. Employment service is a joke. Their staff there cannot communicate with him; he is unable to fill out their forms; and none of their counselors would even consider going out on a job interview and interpreting for him.

The point is comprehensive, specialized placement services are desperately needed for Dorsey and his counterparts. Without them all of the training and other dimensions of rehabilitation will be for naught.

Interpreting Services—Interors can open the door to jobs, education, religion, mental health treatment, legal help, and a multiple of services basic to rehabilitation. More opportunities for hearing people to learn sign language should be provided and some should be encouraged to become interpreters. If the bright, educated deaf people of this country need interpreters, just think about Dorsey and the thousands of deaf people like him.

Summary

Undereducation has continuing and far reaching effects on the lives of not only deaf people, but anyone, especially those who have handicaps. However, those who are deaf face the added burden of a communication problem. The problem is great but not insurmountable. If the 10 fundamental needs outlined above are met, it would help make it possible for many of these people to live useful and productive lives. The challenges we face is to come up with the programs to meet these needs. Such programs represent an investment in deaf people on which society can expect a healthy financial return. They do not represent charitable contributions that cost taxpayers money because they declare dividends.

Dr. Vernon is Professor of Psychology, Education of the Deaf Program, Western Maryland College. Ms. Hyatt is a graduate student in the Counseling Department, Gallaudet College. She has been profoundly deaf since the age of 7.

Review: An Inaugural Edition

Christopher Wood

Annual Review of Rehabilitation, Edited by Elizabeth L. Pan, Thomas E. Backer, and Carolyn L. Vash. Springer Publishing Company, 200 Park Avenue South, New York, New York, 10003. 400 pages. hardcover, \$27.50.

This first annual "check-up" on the overall health of rehabilitation in the year 1980 makes the prognosis for the coming decade look very promising. Rehabilitation is moving forward into the 1980's with an increasingly comprehensive system of services and a broader outlook on the needs of disabled people. As the field differentiates itself and grows more complex, the need for coordination grows steadily. Information resources which improve communication and link consumers, researchers, practitioners, and policy makers are vital to the continued growth and survival of rehabilitation. The *Annual Review of Rehabilitation* promises to be such a resource.

The review provides easy access to the rapidly accumulating body of information in the field. The three editors of this first edition cite the need for a "knowledge integrating mechanism" and trace efforts to develop an annual review back to the 1950's. The springboard for Volume I, 1980 was a project funded under RSA's research utilization program in which all three editors participated. This project developed monographs on urgent topics in rehabilitation which were identified by a consumer panel. The four project monographs

produced were condensed and incorporated into this first Review.* The unique consumer panel mechanism involving disabled consumers, rehabilitation counselors, administrators, researchers, and RSA was expanded and used as the review's advisory board. This panel is undoubtedly responsible for the diversity of the review which balances the interests of practitioners, administrators, and researchers while creating an inevitable unevenness in the text.

Like good case managers, the editors have attempted to pull together many disparate resources to support a volume which addresses a multiplicity of needs. Drawing on their past experiences with information utilization, they have provided for user input not only in terms of selecting topic areas but also in determining how best to present information to target audiences. They have achieved some success in moving away from, as they put it, "... the dry, scholarly tone of many other annual review volumes." The various chapters begin with abstracts and many include introductory text to outline the material which the chapter presents.

Other formatting features, such as the use of bullets, numerous sub-headings, tables, and diagrams, add

*The annual review is not now, nor was it in the past, supported financially by the Rehabilitation Services Administration.

to the readability of the volume and allow the reader to zero in on specific areas of interest. The editors have provided indexes, and they mention sources of additional information believing that ultimately the review should be a starting point for readers to follow up, through "personal contact." In this way the annual review can serve as an impetus for change.

Howard Rusk, in his foreward, dedicates the reviews to just this ideal: "To place what we know in reasonable perspective and see the unified nature of knowledge is difficult enough. To utilize this knowledge to effect changes is still more difficult. To attempt to anticipate the need for change is the great challenge to which the review is dedicated." This need for change is stressed in several of the more forward looking chapters.

Susan Stoddard provides a timely review of the state of the art in independent living and presents an outline for further development. Thomas E. Backer writes of "New Directions in Rehabilitation Outcome Measurement," emphasizing that a broadening of outcome criteria to serve various purposes and audiences is called for. He articulates the concept that outcome measurement is "everyone's business" by demonstrating how it is directly connected with so many other aspects of rehabilitation services. "Consumer Involvement in Rehabilitation," which has had increasing impact through the 1970's, is highlighted in an article by Frank Bowe, Frederick A. Fay, and Janet A. Minch. The authors call for expanding "meaningful" consumer involvement in all phases of rehabilitation and developing more research on consumer participation. Robert Humphrey's lead chapter "Disability in America: 1980 and Beyond" argues for a truly comprehensive service de-

livery network and a national policy to support it while Herbert Dorken's thorough presentation, "Perspectives on National Health Insurance and Rehabilitation" analyzes the profound impact that various NHI proposals could have on rehabilitation and outlines recommendations for NHI.

The current status of several significant dimensions of rehabilitation are examined in chapters on: "Rehabilitation Engineering," James B. Reswick; "Sheltered Industrial Employment," Carolyn M. Vash; "Continuing Education," James A. Bitter; and "Developing Evaluation Standards for Vocational Rehabilitation," Linda Barret and Susan Shea. Reviews geared toward the needs of individual practitioners and their

clients include: "The Psychological, Social, and Vocational Adjustment to Spinal Cord Injury," Roberta A. Trieschmann; "Rehabilitation Following Severe Burns," Garry S. Brody and Mark A. Johnson; "Chronic Pulmonary Diseases," William F. Miller; and "Sensory Disabilities," Hilde S. Schlesinger and Margaret Lee. As is evident from this brief synopsis, Volume I of the review truly has something for everyone. The ambitious future "Master Plan" contained in the review introduction and developed in collaboration with the advisory committee calls for like coverage of many topics on both an intermittent basis and a regular rotating schedule of every 3 or 5 years.

The blend of theory, research, and practice in this review distinguishes it from reviews in other fields and accurately reflects the current diversity and changing nature of rehabilitation. The *Annual Review of Rehabilitation* appears to be the "knowledge integrating mechanism" its editors called for. Howard Rusk speaks clearly to this need for integration in the dynamic field of rehabilitation when he says, "Its research can no longer be the avocation for a few but must be a basic part of service program planning and development." Let us hope that the review becomes just this.

Christopher Wood, M.A. CRC, is a graduate student intern in the Clearinghouse on the Handicapped.

TOPIC OF STATE

(Continued from page 2.)

summer was his fifth with the program. He has attended Carthage College and Blackhawk Technical Institute, pursuing a career in food service. . . .

Paul is responsible for all aspects of his small business, from hiring, supervising, and ordering stock to bookkeeping. Every summer, a college student is hired to supervise the four food service sites.

. . . Nowland aided in the arrest of some juveniles who had stolen a checkbook from a park user's car. He became suspicious when the youths couldn't present proper identification to cash a check.

"The program," he concludes, "has been a good experience for me. I don't know where else one could get this kind of management experience."

Nowland cites the benefit of not
8 having to produce start-up money for

such a business, since these monies are provided through the BEP. . . .

—*Newsletter*. Division of Vocational Rehabilitation, Wisconsin.

California Scores Placement First

California has scored another "first" with the vocational rehabilitation of Pamela Polagi, who recently became the first visually handicapped insurance claims telephone report taker in the U.S.

Ms Polagi's successful placement in her new job came about through the cooperative efforts of her employer, the Automobile Club of Southern California, the Sensory Aids Foundation, Maryland Computer Services (MCS) of Bel Air, Maryland, and the Department of Rehabilitation.

Polagi's supervisor at the auto club recognized that her talents were un-

derutilized in the low level position she held. He contacted Steve Thompson, senior counselor at the Pasadena DR office who consulted with Sensory Aids after doing a job analysis of the positions available at the Auto Club. He then enrolled the young woman in an optacon reading program, after which a 4-month pilot project was set up to test the idea of having a blind person trained in the claims reporting job. Sensory Aids and MCS came up with loaned equipment and with the help of Anita Gilb of the Auto club, who was assigned as Polagi's trainer, she met the challenge of learning the tremendous amount of information and skills required to do the job.

At last report, Polagi's performance is approaching the average number of claims processed by her sighted counterparts in just 2 months on the job.

(Continued on page 32.)

Client Motivation and Responsibility

Jack M. Richman, Ph.D.,
and Sol Richman

The new terms and concepts that are in vogue with some professionals who work with disabled persons, minorities, and the poor are most disturbing. Labels such as "protected classes," "privileged groups,"¹ "the new colonialism,"² and the characterization of social welfare programs as "The White Man's Burden,"³ reflect a new, condescending attitude. On the surface, such appellations and attitudes appear charitable and helpful in encouraging the assurance that these groups will receive the benefits and rights to which they are entitled. But there are dangers in such mental images. For society, they reinforce attitudes of hopeless acceptance of inequality and alienation from these groups. For the "privileged" person, they intensify feelings of estrangement, and inculcate in his perception that these people need special considerations to "make it." Yet their feelings arise in a society and in a group that both stress differences and inadequacies rather than strengths and potential. What may even be more important is that these characterizations deprecate the importance of individual and group responsibilities to commitment and actions necessary to achieve the desired normalization that derives from motivated efforts in education, training, work, and group organization and identification.

In our humanitarian and materialistic society, men and women customarily base their self concepts and their community's perceptions of them in terms of the jobs they perform and the money they earn. "We are what we do," has been and continues to be a major human characterization, even before the days of Horatio Alger. In fact, even now, though too often minimized, the Horatio Alger syndrome, which values the self-made man, is far from dead and continues to reflect the expectations of mainstream America.

The iron mask of inequality between mainstream American and the disadvantaged groups of disabled, minorities, and the poor exist as a stark reality. What is important is that this condition can be temporary, and can be changed, even in the context of the limited service delivery systems that exist in the community.

Adjustment to society takes place only through the use of its social, educational, vocational, and socializing institutions. Therefore, when society limits the quality, availability, and use of such established channels to the disabled, the minorities, and the poor, it would seem that it would be up to society to change its prejudicial attitudes and remove such limitations. However, society does not change voluntarily.

Within the democratic process, society yields under special circumstances, pressure from coalition of groups, or in response to a particularly affected group when such a group has sufficient organized and usable democratic power. In the final analysis, the "protected" groups will, therefore, have to depend on themselves and act positively in their own behalf, not only to take advantage of the temporary protectionism provided to educate and train themselves but also organize themselves as a power group and acting in concert with other socially minded groups in society, insure that the basis for future protectionism becomes necessary.

These groups are further hampered by the use and dependance upon a variety of psychological tests and other evaluative instruments that too often fail to make such differentiation between acquired knowledge and true potential ability. If we define intelligence as the application of past experience to current problem solving, then we would focus more on the limitations of past experiences rather than equating current responses with absolute potential ability. We can expand experiences and can provide new and positive ones.

In this context, the helping professions as concerned citizens must 9

function as change agents to the family and society, and professionally act as catalysts for change for the "protected" individuals. The helping professional must learn to understand the nature of these individuals and groups, their motivation and needs, in their experience setting and differentiate between their academic achievement and their true, latent abilities.

The ghetto, for example, is an organized community with social and institutional instrumentalities such as churches, fraternal and community organizations, educational facilities, employment, labor organizations, etc. Their residents reflect the habits, customs, traditions, and attitudes which represent norms of behavior *adaptive* to the ghetto culture. It is a "normal" community, in an ecological sense, even though it may differ in some respects from the major culture in some survival or adaptive responses. Therefore, it is erroneous and deprecating to define the ghetto in terms of the "new colonialism" and its inhabitants as "childlike adults,"⁴ who are the "White Man's Burden." Even though such a view may reflect the actual deprivation and discrimination imposed, such limitations in no way reduce the residents' *responsibilities* to use the ghetto community, facilities, and the positive values and opportunities offered there to maximize their abilities.

Former Congressman Adam Clayton Powell stressed, "green power," the power of money, to reduce or eradicate discrimination, provide the wherewithal for living, and develop group influence to deal with the majority power base.⁵ He certainly did not simply emphasize the crass ability of money to buy power and respect. Rather, it represented the recognition that "green power" was
10 the by-product of education, voca-

tional preparation, and meaningful work. Similarly, "we shall overcome" represents individual and group effort to achieve societal changes that will assure full citizenship for all and the responsibility and ability to use the advantages of such status.

Perhaps it would be instructive to examine these disadvantaged groups in terms of their common problems and solutions. For example, the disabled person is not handicapped unless the individual or the community imposes handicapping conditions.⁶ After the disabling condition is eliminated or reduced, emphasis should be placed on the residual abilities that can be used in training for a job or profession in a suitable job milieu. The source of these conditions are located in job description, duty arrangements, architectural barriers, attitudes of industry, labor, the disabled person himself, and the community. Obviously, these handicaps can be changed. The needs of the disabled group, therefore, include help for parents to accept their disabled child, establishment of needed services to help the disabled person accept, educate, and train himself to use his potential. The disabled person, growing up in such a positive environment, will expect to and be able to use the established educational and vocational facilities, and not be handicapped in a job for which he has been trained.

In the same way, black, hispanic, and indian people and the poor and their families may face and overcome similar problems. Aside from the handicap of *de facto* discrimination which is ever changing, their real disabilities may lie in their lack of motivation to use the educational institutions, vocational facilities for preparation, and identification with specific attitudes and values necessary to adapt to the major culture where the

jobs and means of contribution exist. The key to full citizenship lies in the groups' encouragement and support of each of its members to use his potential. In such a context, each group becomes an organized pressure group that, along with other socially-minded groups, can deal effectively with the central power structure at the city, state, and national level.

Finally, it must be emphasized that there is not and there must not be a real basic difference between these three minority groups and mainstream America. The reality of such groups' living experiences may condition or limit their adaptive techniques to society but they do identify and hold the mainstream attitudes and goals, albeit repressed. The view is absolutely necessary for the individual, the group, and for the society. It offers the opportunity and the ability to build a bridge to such repressed attitudes and goals with appropriate preparatory programs. The converse of this view would mutually acknowledge the existence of an ever widening chasm of difference that could never be bridged by any type of social programs. Therefore, it becomes mandatory to believe in the ability to build the necessary bridges to unify our people, provide access to opportunities, and not to endanger our democratic institutions and processes.

To recapitulate, the road to follow for each of the "protected groups" seems clear and has been successfully taken by groups that came to this country as minorities during the mass migrations of the late 19th and early 20th century. They came searching for freedom and access to opportunity. With few exceptions, they brought the ability to perform labor and some limited skills. They came to sink roots and retain their cultural identification within the American melting pot. They also wore the mask

of difference and faced prejudice. They worked to remove such difference for themselves and their children through vocational and educational preparation and the use of established community instrumentalities. They formed group organizations for political and social purposes. This was their group and individual pathway into the American melting pot.

Perhaps a most important influence and support was provided by each group's leaders and successful members, as they acted as role models and remained involved with their group to help motivate and organize their compatriots. Only in this way did each group organize and maintain its own power base to deal with the powers that be. This approach can work for each of the "protected" groups.

American society continues to be a melting pot of groups. Yet, despite our group interests, we all strongly identify with the concept of equality and full citizenship and would consider it undemocratic, if not downright subversive, to question their reality. We can and do act as a united people when national interests demand it. However, in the main, we continue to retain our racial, ethnic, demographic, economic, and industrial identities and often act according to perceived group interests. The American melting pot does not require giving up positive sub-culture values, but sets them in the context of the major culture. There need be no culture conflicts. However, the qualities and skills required to adapt to society are essential since it is society that offers the jobs and benefits and acceptance into the mainstream. The media is still the family, its economic level, support, and role model. The person still has to be motivated to prepare himself socially, educationally, and vocationally to contribute and receive his just return. The group

has to organize itself for the continuation of its values and to exert its influence in the democratic process. These are the real determinants of status. This is unity in diversity in action.

Society, the most effectively organized group or coalition of groups, sets the conditions for the person to become part of the social and economic mainstream. Other organizations and coalitions exert pressure and effect change, as needed. However, each person, at any point, has only the choice to meet or reject the existing requirements and reap the consequences of his decisions.

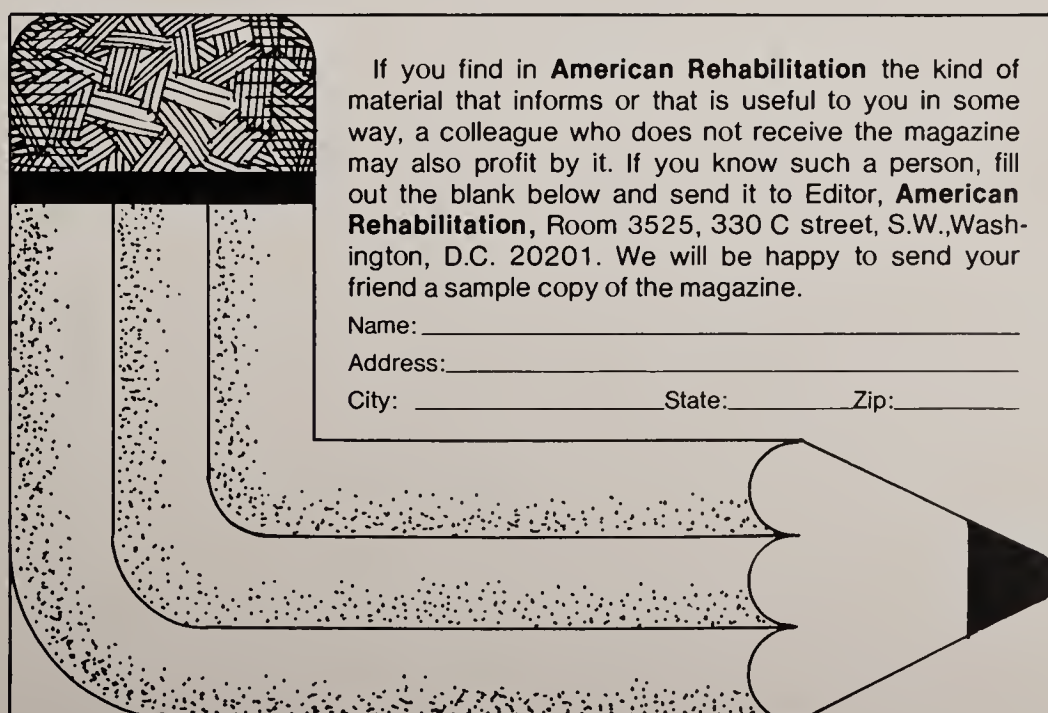
The views expressed may not be new. The concept that disadvantaged groups must take responsibility for themselves to achieve equality must be emphasized. Access to opportunity and equality requires prior preparation. What is done in the short term, determines the long term outcome.

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Social Work, Nebraska Wesleyan University, Lincoln. Mr. Richman is a psychologist and rehabilitation consultant. Mr. Richman was formerly a vocational rehabilitation specialist with RSA's Division of Management and Technical Assistance.

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If you find in **American Rehabilitation** the kind of material that informs or that is useful to you in some way, a colleague who does not receive the magazine may also profit by it. If you know such a person, fill out the blank below and send it to Editor, **American Rehabilitation**, Room 3525, 330 C street, S.W., Washington, D.C. 20201. We will be happy to send your friend a sample copy of the magazine.

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PUBLICATIONS & FILMS

Community Resources For The Social Adjustment Of Severely Disabled Persons: Options For Involvement. Isabel P. Robinault and Caverlee Cary. Research Utilization Laboratory, ICD Rehabilitation and Research Center, 340 East 24th Street, New York, N. Y. 10010. 1980. 136 pages. \$6.

While classical emphasis in rehabilitation has been on work adjustment, it is important to note that success in the working world can seldom be attained without prior, appropriate social and personal adjustments. Even the nonvocational goals of independent living must include a repertoire of responses for productive self-development and participation in society.

To assist rehabilitation personnel, or self-help groups, in their counseling efforts, ICD-Research Utilization Laboratory has culled examples of community resources from all over the USA which illustrate social adjustments that are available to disabled people. The handbook groups the resources under six major categories: Socialization (use of leisure), sexuality (responsiveness and responsibility), personal growth (hobbies and education), community service (consumer advocacy and volunteering), recreation (sports and activities), and transportation (transport options and travel).

The resources in no way imply what *should* be done; they indicate what *is done* now. As such, they provide cues to people in the field who are just approaching these problems of social adjustment, and they suggest needed research and programing by the very

Quick Response Therapy. Judith Goldring. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. \$14.95.

As described in this book. *Quick Response Therapy* is a brief, effective form of treatment integrating aspects of crisis intervention, family therapy systems therapy, and time-limited treatment. The book begins with a detailed study of the clinical theories and processes involved in this treatment. Numerous case illustrations are used to demonstrate the actual therapeutic techniques.

This therapeutic method was developed at Jewish Family Service of New York City, and it has been used since 1971 as the mode of treatment for the majority of the agency's clients.

An Activities Of Daily Living Curriculum For Handicapped Adults. C. Tiller and C. Wyllie. Twin Falls, Idaho: Magic Valley Rehabilitation Services, Inc. 1978. (Available from Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin-Stout, Menomonie, Wisconsin 54751. Order Reprint series No. 20.)

The goal of this 800-page task analyzed curriculum is to provide a format for teaching skills for daily and independent living and skills required for handling the responsibilities of competitive employment. The curriculum includes instruction in such basic skills as money handling, measurement, telling time, reading, writing, cooking, shopping, personal identification, telephone use, post office use, clothing care, housekeeping, personal hygiene and grooming, and transportation.

The curriculum is printed in such a manner that people who have no formal training in teaching skills can use the curriculum effectively in order to teach basic living skills to handicapped adults. The curriculum was developed primarily for use with the moderate and borderline retarded person.

Magic Valley Rehabilitation Services, through a grant from the Idaho State Developmental Disabilities Planning Council, developed this instructional curriculum for use in group homes, sheltered workshops, and rehabilitation facilities. MDC has reprinted this very comprehensive document because of its value to rehabilitation professionals in teaching skills in many areas of independent daily living and personal/social adjustment.

The Life Cycle of Groups. Group Developmental Stage Theory. Roy Lacoursiere, M.D. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. \$24.95.

Based on extensive research and observation, the author concludes that there are predictable developmental stages during the life cycle of groups. These stages—orientation, dissatisfaction, resolution, production, and termination—occur under conditions which are explained, and are perceptible not only in groups, but in other experiences as well, for example, rebellions, moving one's residence, and possibly, "being in love." This work will be of value to mental health professionals, group therapists, social psychologists, educators, and sociologists.

Qualitative Sociology. Editors: Barry Glassner and Derral Cheatwood. University Sciences Press, 72 Fifth Avenue, New York, New York 10011. Quarterly. Individuals, \$18.00; Institutions, \$38.00.

A broad spectrum of topics and research methods are featured in this journal, including theoretical essays, fieldwork studies, photographic studies, and qualitative interpretations of quantitative data. The editors attempt to involve subscribers as often as possible as reviewers of manuscripts, and do not restrict the kind of methodology used, or the theoretical and philosophical stance employed.

Becoming a Family Therapist. Charles H. Kramer, M.D. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. \$19.95.

This book provides a detailed analysis of the personal process of becoming a family therapist, and examines specific therapeutic techniques. Typical personal and professional difficulties and their resolutions are discussed, and the similarities and differences from other forms of psychotherapy are explained. This work should be valuable to family therapists, social workers, psychiatrists, educators, students, and counselor-trainees.

Practicing Psychotherapy. Edmund Neuhaus and William Astwood. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. \$16.95.

This text introduces beginning therapists, trainees, and students to the fundamental issues and dynamics of psychotherapy. It presents principles and practical techniques that remain constant in all forms of therapy regardless of the counselor's theoretical orientation. The book also examines an often neglected area in the training of psychotherapists: The patient and therapist are individuals. This is an informative text for beginning therapists, trainees, and students in the fields of psychology, psychiatry, social work, and counseling.



Tom and Virl Osmond have been deaf since birth yet their artistic, dancing, and piano playing talents have become important elements of Osmond family entertainment. Their story is told in Walt Disney Educational Media Company's film "The Truly Exceptional: Tom and Virl Osmond." © Walt Disney Productions.

The Truly Exceptional: Tom and Virl Osmond. Walt Disney Educational Media Company, 500 South Buena Vista Street, Burbank, California 91521. Color. 14½ min.

This is the story of how the hearing impaired Osmond brothers have made a place for themselves in the world's most famous musical family.

The movie is narrated by Jill Kinmont Boothe, whose own story of bravery in overcoming a physical handicap was told in the picture, *The Other Side of the Mountain*.

The film shows us Tom and Virl through the eyes of their parents, their show business brothers and sister, and their wives and children. With hon-

est, sensitive dialogue, they reveal the special problems and unique rewards shared by the entire family.

Tom and Virl, in their own words, tell of the frustrations of growing up deaf in a musical environment. Both searched for ways to overcome the fact that they would never be part of the singing Osmonds. Now, the brothers' artistic, dancing, and piano playing talents have become important elements of Osmond Family entertainment.

In focusing on two individuals, rather than on the physical problem of deafness, the film tears down preconceptions and stereotypes about the handicap.

Notes on the margin...

Chicago Institute

In recognition of the International Year of Disabled Persons, the Rehabilitation Institute of Chicago has announced a 7-day International Symposium on Independent Life in Chicago, May 3 through 9. The symposium will have the cooperation of nine other organizations and will feature lectures, panels, discussions, receptions, an open house, an art fair, and a film festival. Although the first day's activities are free, there are tuition fees for subsequent days. Full information is obtainable from Rehabilitation Institute of Chicago, Education and Training Center, 345 East Superior Street, Chicago, Illinois 60611. Telephone: 312 649-6179.

First in Illinois

The Counselor Training With Hearing Impaired program at the Northern Illinois University (DeKalb) has been accredited for 5 years by the Council on Rehabilitation Education. It is the first deafness rehabilitation training program to receive such accreditation. The program is directed by Gary F. Austin, Ph.D.

Psycho-Social conference

The Social Center of Alexandria, Virginia, will host the Sixth Annual Conference of the International Association of Psycho-Social Rehabilitation Services, May 28, 29, and 30 at the Key Bridge Marriott, Washington, D. C. To obtain further information, write IAPSR/Program Committee, Care of The Social Center, 2810 Dorr Avenue, Fairfax, Virginia 22031.

Job placement

This item is from the Newsletter, The President's Committee on Employment of the Handicapped: "Local public employment offices around the country are more effective in placing mentally retarded workers than they are in placing all other handicapped persons. Here are the figures for this past year: Of the 845,000 handicapped people applying for jobs last year, 27 percent were placed; of the 27,500 mentally

retarded people applying for jobs this past year, 35 percent were placed.

"Suggestion: People in special education, rehabilitation, workshops, and other fields perhaps ought to make more use of local employment offices in finding suitable jobs for their retarded clients."

Agency profiles

The National Health Council has released Profiles In Health Caring, a publication which highlights the extensive efforts of 19 of the nation's leading voluntary health agencies--all of which are members of the council.

Commenting on the publication, council president Joseph V. Terenzio said: "By adhering to the council's membership eligibility criteria, these organizations have assured the public, which supports them, that they subscribe to standards and practices of performance and reporting which assure that the moneys contributed are indeed spent for the humanitarian purposes intended. ..."

The 19 organizations received \$452 million in FY '78/79 contributions from the public. Ninety percent of this public support was spent to provide program services. They spent \$152 million on patient services, \$97 million on research, \$72 million on public education programs, \$50 million on community services, and \$37 million on professional education.

Sign of times

The American Conservatory Theatre in San Francisco has arranged to have performances of three of its plays interpreted in sign language. ACT director William Ball describes the series as a "pilot program" to test the idea of having all of the noted repertory company's plays signed in the future.

Engineering ensemble

The Annual Conference on Rehabilitation Engineering will be held August 30 through September 3 at the Sheraton Washington Hotel, Washington, D. C. The Rehabilitation Engineering Society of North America is sponsoring the event. For further information: Convention Management Consultants, 5401 Kirkman Road, Suite 550, Orlando, Florida 32805.

ACCESSIBLE COMMUNITIES



A little planning can make a big difference to everyone. **Accessible communities** allow the physically handicapped a share in local activity; it allows the aged to get around; the temporarily disabled to minimize their problem; and everyone to feel a part of the community.

A good feeling. A smart move.



ACCESS AMERICA

Carl Goodman

The Architectural and Transportation Barriers Compliance Board has approved guidelines and requirements for uniform accessibility specifications in federal and federally-funded buildings.

The rule, prescribing how the federal government must make itself architecturally accessible to millions of disabled and elderly citizens, will affect new construction, renovation, and leased facilities. The rule was published in the January 16, 1981 *Federal Register*.

Mason Rose, who chairs the board, said that "the board expects that other federal agencies and some states may use its rule to reduce confusion in currently conflicting access standards."

Rose, public member from California, said that, in new construction, the regulation entails minimal additional cost. Although cost was a serious concern of members, one agency, the Department of Defense, estimated the rule would add less than one-half of one percent to its new construction cost. The General Accounting Office published comparable estimates in a 1975 report to Congress.

"Most of the members feel the rule takes the least costly approach to providing the degree of access required by law," said Rose, a disabled veteran and attorney.

By issuing the guidelines and requirements, the board complies with a 2-year-old mandate from Congress.

Within 1 year, the General Services Administration, U.S. Postal Service, and the departments of Housing and

expected to issue accessibility standards. These standards must be at least as strict as the board's rule and will be used in the construction and alteration of buildings required to be accessible under the architectural Barriers Act.

Donald Elisburg, assistant secretary of Labor and vice chairman, called the rule "a major step forward for both the handicapped community and the government, creating a reasonable approach to access for all."

The rule climaxes more than a year of research, field experience, and public rulemaking.

The regulation includes minimum numbers and technical requirements for parking, entrances, elevators, assembly areas, telephones, and restrooms. Visual alarms and telephones adapted for use by deaf and hearing impaired people are also specified. For blind and visually impaired people, requirements on signage and for warnings on doors to hazardous areas are included.

The technical specifications are based largely on the 1980 American National Standard Institute's (ANSI) access standard.

The rule, as proposed August 18 in the *Federal Register*, would have required that in any building constructed with federal funds, all entrances, restrooms, doors, windows, and water fountains be accessible to and usable by handicapped people. To make the rule more cost-effective, it was tempered by reducing the number of accessible entrances in most instances and by requiring one accessible door to each accessible room or space. One half of all water fountains must be low enough to be used by people in wheelchairs and little people. The final rule defers for further study telecommunications devices for deaf people. Several provi-

sions were modified to provide more flexibility in complying with the rule.

The rule requires that, when such elements as restrooms, and stairs of an existing building are altered, they must be made accessible.

If a building undergoes substantial alteration, one entrance and one restroom must be accessible. Substantially altered multi-story buildings must have elevators or lifts.

The section of the proposed rule carrying out a 1976 law requiring that all buildings leased by the government be accessible aroused considerable controversy. The final rule attempts to satisfy the objections of certain agencies by permitting exceptions for emergencies and lack of accessible space in remote areas.

Blind Programs Evaluated By RSA

The Rehabilitation Services Administration has announced the evaluation study entitled, *Evaluation of RSA Programs for Blind and Visually Handicapped Persons*, has been completed by JWK International Corporation. The final report consists of an executive summary, utilization seminar report, in-depth study report, national report, and individual state report. Copies will be distributed to the various state vocational rehabilitation agencies that serve blind and visually handicapped clients.

Anyone interested in obtaining copies may do so through the National Rehabilitation Information Center, 4407 Eighth Street N.E., Catholic University, Washington, D.C. 20017; telephone (202) 635-5822. Copies will be available in print or tape cassettes. A nominal fee will be charged.

Administrative Strategies in Rehabilitation: Retrenchment Or Stability?

Gerald K. Wells, Ph.D.,
Laura A. Edwards, and
David R. Ziskind

"Sweet are the uses of adversity; which, like a toad, ugly and venomous, wears yet a precious jewel in its head;"—**Shakespeare**

The rapid changes of the past 15 years in rehabilitation, without extended periods of adjustment, can only have left rehabilitation administrators angry, frustrated, and pessimistic about the future. At the period's beginning, in the 60's, rehabilitation overflowed with optimism. The rehabilitation movement was working with greater numbers of disabled people; and, many felt, with the support of Congress and the heightened awareness by the American public, rehabilitation might finally fulfill its philosophy that: "Every member of a democratic society has an inherent right to the opportunity to earn a living and make his contribution to society."¹

Yet, despite this optimism, there were rumblings of discontent. Many groups and individuals, particularly the organized disabled, were expressing concern that the rehabilitation service delivery system was no longer adequately meeting the needs of the more severely disabled. This led Congress, in the Rehabilitation Act of 1973, to redirect the program, ushering in a priority of service to the

severely disabled, giving a stronger voice to disabled consumers in patterning the services affecting them, and bringing upon the program greater measures of accountability. An inscription on a recent calendar, *By the time we had all the answers, they changed all the questions* seems to express the dismay of many rehabilitation administrators at these radical changes.

Nevertheless, through this agonizing period of adjustment shone a new hope. Title VII, Part B of the amendments of 1978—known as the independent living legislation—offered further expansion of rehabilitation services provided for in the Rehabilitation Act of 1973. Title VII opened the doors for the more severely disabled who had no vocational potential to receive rehabilitation services. It also brought service providers and service recipients into a working partnership and provided for a greater unity in the rehabilitation movement. Now, however, the American economy has turned downward, leaving both Title VII and the traditional rehabilitation program with what many consider less than adequate financial support. The condition sends waves of unrest and insecurity throughout the whole rehabilitation system.

For administrators, a glance at the future suggests further bleakness with decreasing dollars, tighter controls, continued change and adjustment, and a state of retrenchment. As the beginning quotation suggests, adversity is ugly and venomous; these trying times test everyone's patience and endurance. But the "precious jewel" to be found in the future may well lie in the ability of managers to handle this adversity. The choice lies between following the familiar patterns of crisis management dealing only with staff insecurity, grievances, and reallocation of shrinking resources, gradually becoming isolated from the support of other levels in the organization; or, while dealing with immediate concerns, reaching out to others dependent upon administrative leadership and build strength and stability into the organization.

Although the second option is more attractive, the question remains—how is this done? The purpose here is to draw attention to a model that, with adaptations by creative administrators to their unique settings, may lead to unity and stability in their organizations. The model is described in depth in the publication, *Shaping The Future: A Systems Approach to Human Resources Development in Vocational Rehabilitation Agencies*. This article 19

describes the model's evolution and briefly discusses some of its major concepts and practical suggestions.

Success Depends On Employees

The model sprung from a concept inspired by Corbett M. Reedy, former Acting Commissioner of the Rehabilitation Services Administration. He believed, as most of us, that quality and success depended upon the capabilities of a diverse group of employees—professionals, technical experts, managers, and support personnel. Seeking the most gifted staff possible, developing them to full competence, and enabling them to achieve their utmost potential, therefore, is the top priority of organizational leadership.

What was lacking, he felt, was a model design for agency administrators to use in making their organization responsive to the professional staff—those people with the authority to achieve the goals of rehabilitation.

Employees Help Design Model

From this beginning, the administration of the Virginia Department of Rehabilitative Services and the staff of the Regional Rehabilitation Continuing Education Program, which is a part of the Virginia agency (RRCEP-DRS), understood that the design of the model must be comprehensive in nature and must involve practitioners and educators alike. It was believed, and confirmed, that the contributions of practitioners and educators working together would bring to the model design a unique combination of the day-to-day knowledge and experience of agency staff and the educational techniques and philosophy from RRCEP-DRS educators. This project was supported and encouraged by Dr. Ralph Pacinelli and his staff of the Rehabilitation Services Administration,

Federal Region III.

The project staff formed committees from all levels of staff within the Virginia DRS agency—counselors, secretaries, evaluators, trainers, supervisors, and managers—to investigate key areas of a human resources system. An executive committee was established to review committee reports and develop from these reports a model for a comprehensive integrated human resource system. During and following the activities of the executive committee, RRCEP-DRS staff studied widely human resource systems in business, industry, and government. Among the research activities was a national survey of administrators of vocational rehabilitation agencies to determine the state of the art in human resources management and development.

The result of this 4-year intensive research project, *Shaping The Future*, is both a practical and conceptual design for human resources management. This project is both ambitious in its scope and somewhat presumptuous in its intent, purporting to be a model, designed around a single agency, yet adaptable, all or in part, to most human resources organizations. Yet, though admitting the inherent limitations, the contents seem consistent with the finer principles of rehabilitation philosophy and practice, and with sound administrative procedures.

Emphasis On Individual Growth & Initiative

Shaping The Future places emphasis upon individual growth and initiative. People choosing to work in rehabilitation must make a conscious, deliberate career decision; they participate in contract learning experiences to improve their abilities; they assist in the design of their own evaluation; and they select the direc-

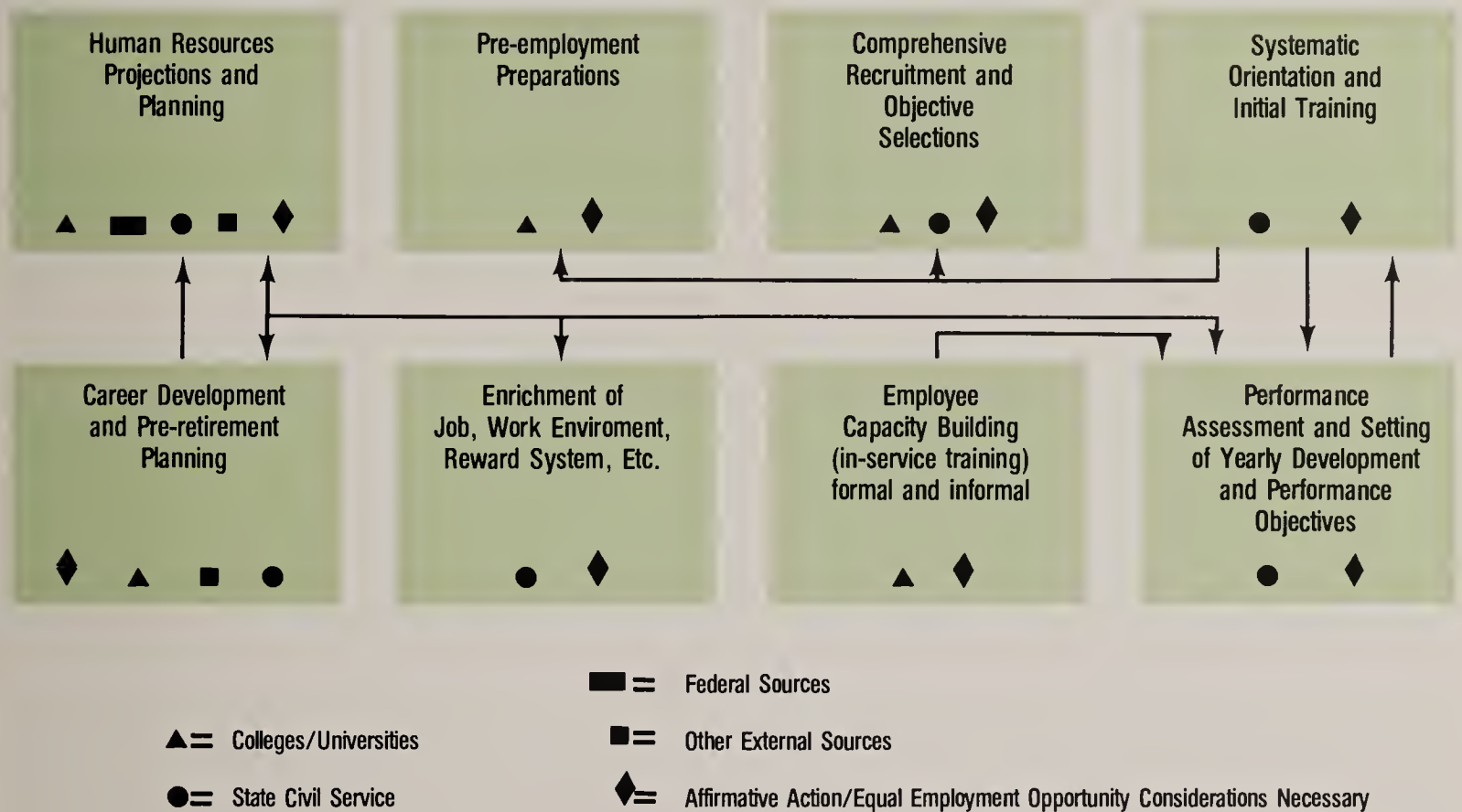
tion necessary to fulfill their career objectives. Thus, the model encourages participation, initiative, creativity, and commitment, qualities long recognized as necessary ingredients to a successful program. Moreover, *Shaping the Future* suggests a conceptual, organizational design which places independent systems into a sequential inter-related human resource system and suggests actual implementation strategies.

Finally, *Shaping The Future* follows recognized principles for the management of human resources. The model attempts to lay a foundation that balances individual freedom and latitude with agency administrative guidance and direction. It begins with a procedure for planning human resources, suggests ways the agency may organize its human resources program, indicates coordination among functions to carry out the program, and, finally, provides ways the effectiveness of the program may be measured (see Figure 1 for schematic overview.) The human resources program, thus, becomes a joint, participative effort between the organization and its people.

Proactive Approach Through HR Planning

The foundation for a comprehensive human resources program and the first component of the system is *human resources planning*. Three types of planning are considered: *continuation planning*, methods for maintaining the present program level with existing types of personnel in the future; *programmatic planning for new ventures*, a procedure by which organizations would try to anticipate new program ventures by deciding early upon the purposes, goals, and objectives of the new venture, identify the job functions affected and needed, and identify in advance the

Figure 1
Functional Flow Within A Human Resources Program



knowledge, skills, and attitudes needed to perform effectively in the new program; and *long range planning for human resources*, a practical procedure that allows administrators to make a smooth transition into new directions and make the necessary adjustments in the organization to new and changing conditions.

By planning ways to have the right people available to continue existing programs, to prepare for new ventures, or to make long-range changes in program directions, the administrator can assure minimum variances between supply and demand for personnel. Even in nongrowth periods or reductions, human resources planning assists in making more efficient use of existing personnel, thus reducing needless fears and frustrations. Human resources planning, therefore, is problem preventive rather than so-

lution oriented. It saves confusion, delays, and haphazard actions.

Assertive Job/Person Matching

If human resources planning can be considered the foundation of a successful program, then, certainly, a well-designed and directed recruitment effort is the door to its fulfillment. While planning operates inside the organization to determine present and future needs for staff and outside the organization to cultivate sources capable of producing the right persons, recruitment and selection, on the other hand, reaches out on a personal level to locate and enlist those persons possessing the talent to succeed in the organizational setting. Thus, planning and recruitment and selection are closely related parts of a continuous human resources program. *Shaping The Future* provides recruit-

ment and selection strategies that use:

- Central office coordination and leadership, especially in the recruitment and screening process, and local responsibility for the selection.
- A recruitment strategy built on identified personnel goals, active development of sources of applicants, use of applicant pools, and job specific hiring specifications.
- A screening strategy encompassing centralized weeding of qualified and unqualified against hiring specifications, gross sorting among qualified, and the referring of designated numbers of applications to the local supervisor.
- A selection strategy focused on reducing biases through systematic interviewing, paired comparisons, and committee involvement.

Amid hiring freezes and decreased numbers of persons coming into the 21

organization there is a tendency to reduce recruitment, to draw attention to more pressing matters at hand. Ironically, with fewer positions to fill and with peak demands upon organizational talent, mistakes in hiring are least affordable during these times.

Systematic Employee Capacity Building

Success in human resources planning and in recruitment and selection depends upon the responsiveness of people and organizations largely outside the control of the administrator. Once a person is employed, however, the rehabilitation organization gains command of many of the varying factors which can contribute to a productive and creative workforce. Employee's satisfaction, their ability and willingness to work cooperatively toward fulfillment of established goals and objectives, and their desire to remain in employment once they have gained full competence depends, to a great extent, upon the receptiveness of the working environment. In the section entitled "Employee Capacity Building" *Shaping The Future* provides a plan for:

- *local office orientation*. First impressions are lasting impressions. The initial contacts and experiences of new employees frequently shape and solidify long-lasting attitudes, perceptions, and motivation toward the job.

- *central office orientation*. The extent to which the new employee feels an identity with the central office may arise from the impressions gained during this visitation.

- *an induction training process*. The induction training phase of this model goes hand in hand with orientation activities and is strengthened by well-developed and applied curriculums using jointly-developed learning contracts.

- *an evaluation process*. The assessment process provides the necessary structure not only for supervision of employees within agency policies, procedures, and practices but also for increasing communications between levels of staff, for better use of employee potential, and for enhancing growth and professionalism.

Employee Capacity Building picks up where the preemployment preparation ends, assuring that learning becomes a continuous, integrated, and sequential process.

Career Management

While career management finds its natural place at the end of the human resource continuum, its success depends upon the effectiveness of prior systems. Human resource research and planning detects trends in employee movement and predicts future job areas toward which employees may plan their careers. Employee capacity building provides the framework in which an employee attains competent status in the present job and begins looking toward further career fulfillment. Thus, career management adds the last major component to the human resources program and interacts with the preceding related systems.

The career management approach in *Shaping The Future* places emphasis not only on career advancement but also on satisfaction in the present job. Most employees desire work that, in so far as possible, offers challenge and responsibility, appropriate and timely recognition, and opportunities for significant accomplishments. The organization may well find as much success in enriching the environment of work as in providing career mobility. The model design suggests some of the ways of enriching the work environment. A well-managed career management

program can lead to high levels of production and a continued commitment; while at the same time, avoiding stagnation and burnout.

No Panacea

The systems of this model program offer no panacea for solving the troublesome problems currently affecting rehabilitation organizations. Restricted funding in a high inflation economy and tighter accountability measures for programs will doubtless continue. Despite these adverse conditions, however, the administrator is expected to provide the best possible rehabilitation services within the constraints of available resources. Amid the present difficulties it seems most appropriate for administrators to seek out a management system which fosters participation, initiative, creativity, and commitment, bringing all the people in the organization into a working partnership. The administrator may find greater success by adopting a planned mode of action, becoming proactive to conditions, both within and outside his/her control.

Dr. Wells is Director, RRCEP-DRS, RSA, Region III; Ms. Edwards is Training Services Coordinator, RRCEP-DRS; and Mr. Ziskind is Deputy Commissioner, Virginia Department of Rehabilitations Services.

NOTE: Editions of *Shaping The Future* may be obtained by sending \$6.00 for handling and mailing to: RRCEP/DRS, Box 367 WWRC, Fishersville, VA, 22939.

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By Ned Burman

IYDP News And Notes From Here and There

News of the International Year of Disabled Persons will be given added emphasis during 1981. In keeping with the IYDP theme of full participation for all people with disabilities, this column will carry news of significance to handicapped people.

The Canadian Rehabilitation Council for the Disabled (CRCD) has identified six key topics for 1981, the International Year of Disabled Persons (IYDP). The CRCD and its member organizations will focus attention and efforts on transportation, housing, environmental barriers, recreation, employability, and public attitudes toward disabled people. A public awareness campaign will be conducted at the national level using posters, magazine ads, and radio.

PCEH Honors the International Year of Disabled Persons, May 6, 7, 8, 1981 at the Washington Hilton Hotel in Washington, D.C. In 1980 the PCEH Annual Meeting and Exhibition last year attracted over 5,300 participants including the President of the United States.

President-elect Ronald Reagan pledged his "personal cooperation" and joined in issuing a national call to action in behalf of America's disabled population during 1981. Mr. Reagan's statement of support stressed his pride in the achievements made on behalf of California's disabled people while he was governor.

Rehabilitation International has opened a speaker's bureau for the International Year. It is one of several activities mounted by them as a support program for IYDP. For further information, contact Rehabilitation International, 432 Park Avenue South, New York, N.Y. 10016.

The U.S. Council for the International Year reports from the private sector that 265 national organizations have joined its "Corporate Partnership Program" in which companies undertake special initiatives on behalf of disabled people. Chairman of the U.S. Council is David Kearns, President of Xerox Corporation.

The Rotary Foundation Awards. Eighty-five scholarships to teachers of handicapped worldwide. During 1981-82 the foundation will present awards to 85 men and women from 32 countries. They will study in a country other than their own, learning new teaching techniques in the host country for 1 academic year. Applicants must have at least 2 years of full-time experience as teachers of handicapped people and be between 25 and 50 years of age. For information, contact any of the more than 18,800 Rotary Clubs in 154 lands throughout the world or the Rotary Foundation, 1600 Ridge Ave., Evanston, Ill. 60201.

The National Railroad Passenger Corporation will spend \$2.9 million in 1980-81 fiscal year to provide barrier-free access to trains at 18 stations: Chicago, Milwaukee, Minneapolis/St. Paul, Detroit, New Orleans, Kalamazoo, Michigan, Syracuse, N.Y., Champaign, Illinois, Macomb, Illinois, San Luis Obispo, Ca., Whitefish, Montana, Flagstaff, Arizona, Florence, S.C., White River Junction, VT., Ocala, Fla., Harper's Ferry, W. Va., West Quincy, Mo., and Minot, N.D. Later in the fiscal year, work is scheduled to begin on five other stations: Penn Station in New York, Baltimore, Houston, Wickford, R.I., and Reno, Nevada. Modifications will include work on

entrances and exits, interior doors, baggage and ticketing areas, lounge areas, restrooms, platforms, curbs, loading zones, parking areas, information displays, telephones, and drinking fountains.

The National Spokesman reports that employment of people with epilepsy may have a positive impact upon reducing the numbers of seizures in those epileptics whose seizures are not controllable by medication. Dr. Robert Fraser, Coordinator of Vocational Services at Harbor View Medical Center, said that concentrating on a task and/or involvement in physical activity lowers the number of seizures.

The International Skill Contest for the Disabled (International Abilympic) will be held in Tokyo, October 21-23, 1981. The event is described as the Olympics of Ability and aims to encourage disabled people to improve vocational skills and to promote employment of disabled people through increased public understanding in regard to ability and performance of normal work.

Rehabilitation International is one of the host organizations cooperating with the Japanese government. For information, contact them at 432 Park Avenue, South, New York, N.Y. 10016.

Johns Hopkins University announced a nationwide contest search to inspire new inventions that apply personal computers to the needs of handicapped people.

The contest is funded by grant aid from the National Science Foundation and the Radio Shack division of Tandy Corporation. Grand prize is \$10,000. Last day for submission of entries is June 30, 1981. For more information, contact Personal Computing to Aid the Handicapped, Johns Hopkins Univ., P.O. Box 670, Laurel, Maryland 20810.

Language Used or Used Language?

Obfuscation is a term that defines the art of utilization of many big words so that the pretexts of these words are obscured. Obfuscation is a term that defines the art of utilization of many big words so that the pretexts of these words are obscured.

We recall a bit that we wrote on how anatomy figures into our language: *elbowing* one's way, *facing* up to it, having the situation *in hand*, seeing *eye to eye*, turning one's *back* to the situation, etc. If anatomy plays an important role on language's stage, we suppose that physiology (in an extended sense) fills a lead role also, as we *sit* on the report, *think* the situation through that has made us *nervous*, *run* the gamut, *walk* the dog, *sense* the frustration, *chew* the fat, and *eat* our hearts out.

These delightful cogitations about language were brought to mind by James J. Kilpatrick in a hilarious piece written for the *Washington Star* (December 18, 1980) entitled, "Caught by the Flu." In it, he comments about the peculiar use of verbs: "I have 'caught' the flu. Why 'caught'? I wasn't even chasing the flu." . . . "We are all running a high fever. Why 'running'? . . . I do not want to run fever, or even walk or trot fever." . . . And "I will take my pulse . . . Where in the world will I take the confounded thing?"

Here is the anatomical bit of which we spoke: ". . . Consider the following *profile* . . . 'As *head* of this agency, he must stay *on his toes*, diligently *eyeing* what's *afoot ahead* to know what's *at hand*. This takes *backbone* and *intestinal* fortitude (i.e., *guts*) and not simply *lip* service from a person who doesn't have the

stomach to administer or to sink his *teeth* into a problem. The *cerebral* administrator must have a *nose* for the *hairy* problems that arise. He must have the *nerve* to do his job with *body* and *soul* or *face* the catastrophe.'"

Superabundance. Sue these words for nonsupport.

" . . . responsible for projecting its *own* manpower needs." "It's" says it; own up to it.

" . . . as mentioned previously . . ." The past is stated in the verb; already mentioned, that is!

Geographic area. Area indicates place and, usually, the sentence tells us that we are speaking of geography, at which point, "area" absorbs "geography."

" . . . the lack of *financial resources* to conduct *meaningful* evaluations . . ." Are financial resources the same as money? Well, having gotten the money, we wouldn't expect anyone to conduct nonmeaningful evaluations. The real "lack" here is more than money or evaluations. . . . From the same study that yielded the above, we read " . . . so that states may generate the capacity to provide evaluative studies of their programs and component parts." What is wrong with: "So that states may evaluate their programs," a net saving of 10 words. For, indeed, if a state *conducts a study*, it has "generated the capacity to provide" and, if

it evaluates a program, it must evaluate the "parts" that make up the whole. Besides, a component is a part, and a part is a component. So let's part with most of the components of this phrase!

" . . . finite public monies . . ." Even in the best of times, a trillion dollars to study what makes a firefly glow might not be possible; in the worst of times, there might be no money at all for *that* kind of a study. We are saying that money, no matter when, has a limit (i.e., *finite* does not mean *scarce*; no matter how abundant or how scarce, money is finite.) (How well we know!)

Pastiche. Grab bags are great in junk sales; they have no place in precise writing.

"Maxine Kumin, a Pulitzer Prize winner with credentials in every kind of writing and writing instruction, is one for whom the ultimate precision in communication is metaphor, image, the way two words can come together like the meeting of lovers' glances to set off a psychic explosion." (From *Washington Star*, March 15, 1980, in an editorial titled, "A Visitation of Verbals.")

In the *We Don't Believe It* department: "The size of the envelope must be considered in connection with the content and with the weight of mailed items."

The Promised Land. The difference between the right word and the almost right word is the difference between lightning and the lightning bug.—*Mark Twain*.

"The Down-Filled People," by Tom Wolfe, *Washington Star*, November 27, 1980: "They wear down-filled coats in public. Out on the ski slopes they look like hand grenades. They have 'audio systems' in their homes and know the names of

(Continued on page 32.)



Where Disabled People Live As One Family

Thomas Brubeck

When the Rossows of Ellington, Conn., began building their family, they did not realize that within a decade they would have a fair representation of the world's disabling conditions within their own walls.

Nor was that their intention. During the early years of their marriage, Rachel and Carl Rossow had a typical family. Now, the square footage has expanded and they provide a home—in the full sense of the word—to many others who previously had no alternative to suffering and loneliness.

They have 14 children, all but three of them adopted or permanently-placed foster children, and they have a multitude of disabilities. They have named their home Alpha and Omega—the beginning and the end. From the standpoint of numbers, one might be tempted to call it “an institution away from an institution.” But the

Rossows say it is not an organization. It is a home. And an experience.

When Rachel and Carl met in Washington, D.C. in 1964, they were in for several years of blissful, married life before they hit upon the concept leading to an 11-bedroom house full of unmatched socks, dirty dishes, and late appointments.

Rachel was at Catholic University, majoring in psychiatric-mental health nursing—a choice which would not prove academic. Carl, just out of the Air Force, was a computer scientist. His sense of organization would soon be put to a daily test.

By 1971, the family had three healthy children and was living in Connecticut, having just moved from Bryan, Texas to the small town of Ellington. One day, Carl was reading an article about foster children, and he

was struck by the lack of permanence in the children's lives. He talked to Rachel about adoption and what it might mean to their lives if they took that road.

“We began making inquiries of the Children and Family Services in Connecticut,” said Carl. “They asked us what we thought of handicapped children. Then, we saw Eddy's picture on a poster which said, ‘This little fellow needs a home.’ The pediatrician saw potential in Eddy and wisely knew that he needed an environment outside of the institution.”

The Rossows adopted the boy, and he started the whole thing. In another year and a half, an additional youngster joined the family.

Alpha and Omega, set up as a non-profit organization, really got underway in 1974 when they pooled their resources—Carl the computer scien-



Photos on this page and on page 25 are by Leo Choplin, Black Star company. The photos show the various Rossow children enjoying life to the fullest and, above, is shown one, big, and obviously happy family!

tist and Rachel with education in human services—and tried to visualize what they could provide for a family of disabled children. They knew it would be a full-time job.

“That is when we sat down to plan the concept,” said Carl, “and it was close to what we have today. We figured on a large family, possibly not as large as it turned out. But most of the planning worked out fairly close to the discussions in 1974.”

What has evolved is a way to provide specialized nursing care and supervision in a family setting. The key words are “family setting.”

Another benchmark year was 1977 when they moved from a compact house to one with space. Much thought went into the design of this sprawling house, which is mostly at ground level. There is an office and master bedroom on the second floor. The children have access to the 6,000 square feet on the main floor, and with the amount of rolling stock in use, it does not always seem that spacious.

The family receives financial help from the State of Connecticut for operational expenses. The remainder comes from individual donations. Except for one fund-raising dinner in 1977 for the new home, the Rossows do not solicit for money. But it comes to them. They receive donations from hundreds of people, mostly those who do not have much.

One large burden—the mortgage—was eliminated when Connecticut Governor Ella Grasso and the state legislature sent a check for \$160,000. Another gift came from State Congressman Christopher Dodd, who donated a significant portion of that year’s pay raise to Alpha and Omega.

It is not the family dwelling but the spirit of the family life which works its magic with the children. To the

Rossows, any technical proficiency without love would be as out of place as a lobster in a cookie jar. Their entire approach is to integrate family experience into the children’s development.

“The goal is to make each child as self-sufficient as possible, such as taking a shower, catching the school bus, and getting physical therapy,” said Carl. “We use a physical therapist and an occupational therapist on a consulting basis. Everything is done in terms of everyday life, integrating the activities into the home routine. Therapy takes the form of recreation and sports.”

Most of those who come to live with them are severely disabled. Still worse, they had been homeless. Until this time, they had no alternative to an institution. Rachel commented that rejection is horrible. In a Christmas letter, the Rossows sent to friends when they launched Alpha and Omega six years ago, they said:

“Indeed they are totally deprived children for they suffer loneliness and accuse and punish themselves for this loneliness. Their isolation prevents them from developing the most essential human trust in themselves and in others.”

When the children first arrive at the house, their physical handicaps are obvious. But, the Rossows point out, mental scars from neglect and rejection are the heaviest burdens. The atmosphere of caring progressively permeates their inner being, and slowly the scars begin to fade.

“We are responding to a need,” said Rachel. “Whatever the children need, we just absorb it into our lifestyle. What we are doing is so ordinary, so simple. It is what we’re all about—that we are all brothers and sisters.”

She observes that each child is dif-

ferent and special, yet they have the same problems as other children and the same developmental levels. Children are children, she said.

Rachel said they were asking the children about their goals. David, who has been through much surgery and is in a body cast, said, “I want to get dirty.”

She told about a child who had been written-off by an institution, and she now describes him as “adorable, going into the eighth grade, and giving his mother a hard time.”

“Susan had a big effect on him,” said Rachel. “It’s so neat to see.”

She described the problems of an infant who has only a brain stem. Holding a flashlight by his head, one can see the glow of light through the head, because there is no brain development. The infant does not see, hear, or think, yet there is a gentle pattern of back-and-forth movement which goes on continuously, and about once a day they will see a smile from Benjamin. Rachel uses the full name rather than Ben, perhaps to give him a full measure of something in life. And he has given them something.

“He is a beautiful baby, and has an incredible presence about him. The impact of little Benjamin on people is really profound. I think he represents the very essence of what it means to be human.”

Eddy does not have a tongue, cannot change his expression, and has one leg and two fingers. But he is said to be “a real contemplative and has personality.” He has a gentle side and also a sense of humor. On April Fool’s Day, he nearly demolished their kitchen by quietly rearranging everything.

Simone, who has brittle bones, has widespread interests ranging from

(Continued on page 32.)



International Year of Disabled Persons 1981

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NEWS, NOTES, ANNOUNCEMENTS

Conference And Expo To Be Held In Los Angeles In April

Broadening the schedule for the 1981 International Abilities Unlimited Exposition will be the first International Conference on Comprehensive Rehabilitation and Independent Living, both events to be held concurrently at the Los Angeles Convention Center. While the seminars will begin on April 9, the expo will open its doors the following morning.

The organization of the conference will provide the professional with the latest information on the rehabilitation of severely disabled people and the disabled consumer with ways to establish and manage an independent living center.

Seminars for the professional are being produced by the Daniel Freeman Hospital in Inglewood. Experts from many phases of the rehabilitation process will speak. All of the seminars will give information that can be immediately put into practice. Those who preregister for the seminars receive a discount and free admission to the expo.

Hundreds of exhibitors will participate in the third expo. Exhibits will include thousands of products used by the disabled and the professional who works with him. In addition, educators will be present to talk about training opportunities and major employers will be taking job applications.

The exposition will again be sponsored by the California Association of the Physically Handicapped. Information about the show and booth res-

ervations should be directed to Richard C. Wooten, 2945 Harding Street, Suite 107, Carlsbad, California 92008. Telephone 714 729-0853. More information about the seminars: Conference/DMC, 8100 Garden Grove, California 92644. Telephone 898-9571, or TTY 892-1087.

Intimacy Crucial In Good Marriage

Psychologist Robert P. Travis and his wife, Patricia, say that part of the key to maintaining a healthy, happy marriage is to treat your spouse as though you are not married.

Based on their research, the Traveses conclude that maintaining intimacy is important to a successful marriage and that not taking your spouse for granted is a vital link in maintaining an intimate, beneficial relationship.

In their work at the University of Alabama Medical Center, they concerned themselves with couples who said that their intimacy was lost or gradually reduced after marriage. They observed that though relationships usually manage to grow and become more and more meaningful before marriage, after the wedding (and frequently soon after) things begin to change.

The Traveses cite two reasons for this loss of intimacy. First, "the business of marriage," is what makes many couples spend their weekends redecorating or attending every event their children are involved in. They try to do so much that they have little time left for each other.

The second problem area arises

when they separate their sex lives from other aspects of their relationship. For such couples, affection always ends in sexual intercourse, so that all expressions of intimacy become preliminary to the sex act. The Traveses say that sexual intercourse is a poor substitute for intimacy. When in this pattern, one or both partners can become afraid to show affection since it is interpreted as an overture to intercourse even if intercourse is not desired.

The Traveses summarize their findings in a new book, *Vitalizing Intimacy In Marriage*, published by Nelson/Hall, Chicago.

UCIR Gets 5-Year Grant From NIHR

The University Center for International Rehabilitation (UCIR) at Michigan State University will continue its worldwide efforts on behalf of handicapped people under a 5-year contract from the National Institute of Handicapped Research. Donald E. Galvin, professor of rehabilitation counseling, special education and community health sciences, serves as project director.

This new contract essentially reaffirms the original intents of UCIR: to engage in international exchange of information; to collaborate in international research projects; to enhance the international awareness of the principal U.S. universities engaged in rehabilitation research and training; and to train foreign students in rehabilitation related disciplines. A primary objective of the UCIR project is to assist domestic policy makers, researchers, and service providers by supplying pertinent information from other countries.

The new contract will see a contin-

uation of the existing centers in Jordan and Costa Rica and formalization of new arrangements with the University of Education in Heidelberg. UCIR staff will conduct a 3-week course at Heidelberg this summer, including a tour of rehabilitation centers in Germany, The Netherlands, and France.

Less formal arrangements, which include regular communication and frequent meetings between UCIR and universities in Japan, India, the Philippines, Egypt, England, Canada and Sweden, will continue.

UCIR also cooperates with other U.S. based international programs, such as Rehabilitation International, the World Rehabilitation Fund, and Partners of the Americas.

A major accomplishment in the past 2 years is the identification and clarification of major research goals for UCIR, as well as the initiation of work on each. Among the major goals are: comparative studies of independent living programs; studies of consumer participation in rehabilitation policy development and programs in specific countries; efforts to improve technology exchange between foreign countries; a study of coping with disabilities from different cultural perspectives; working with other organizations to study the new World Health Organization system for classification of disabilities; and the development of an international network to exchange educational media and materials.

Information exchange constitutes a large part of UCIR's program. Much information is received from universities, institutions and clientele abroad, which is in turn evaluated, packaged, and re-targeted to U.S. audiences. Similarly, U.S. information is disseminated abroad.

UCIR has a staff of 8 faculty and

currently has 20 graduate students. In addition to the U.S., the students come from Ireland, Norway, Jordan, Egypt, Costa Rica, India, and the Philippines.

The International Year Is Here

Harold O'Flaherty, Executive Director, Federal Interagency Committee, International Year of Disabled Persons, announced plans for accelerated activity by the Federal Interagency Committee in support of the U. S. Government observance of the year in 1981.

The White House directed the formation of a Federal Interagency Committee, IYPD, to provide stimulation, leadership, and coordination of the United States planning and implementation effort. The committee includes representatives from over 30 federal departments, agencies and commissions, the Executive Office of the President, and the United States Mission to the United Nations. O'Flaherty said the Federal Interagency Committee will function in accordance with the theme that all individuals who have a disability should have the right to live as independently as possible with full participation in all phases of American Life.

United States participation in the year reflects its long-established, active role in supporting national and international efforts to meet the needs of hundreds of millions of disabled people in the world. This role includes its active support of the principles of the Universal Declaration of Human Rights, the Declaration on the Rights of Mentally Retarded Persons, the Declaration on the Rights of Disabled Persons, and the White House Conference on Handicapped Individu-

als.

The Federal Interagency Committee's observance of the International Year is being conducted within governmental jurisdictions while the U. S. Council for the International Year directs the nationwide activity throughout the private sector. The leadership of the FIC and the U. S. Council cooperate fully in serving their special functions in pursuit of the IYDP goals.

Planned activities during the International Year will also lay the groundwork for future developments during the decade of the eighties when the dreams and aspirations of disabled people may finally coincide with reality.

O'Flaherty, who is blind, was appointed to the Executive directorship of the Committee in September 1980 and is on leave from the U.S. Public Health Service.

"The Federal Interagency Committee encourages each individual, each organization, and each federal, state, and local government agency to actively participate in the year on behalf of those disabled individuals in their community, city, or state. The overarching theme of the Committee is 'Come let us reason together.'" The success of the year depends in large measure on the involvement of concerned individuals working through state agencies, civic and community groups—of officials at all levels of government—and of workers and management in business and industry—undertaking activities within a broadly coordinated plan to heighten public awareness of the capabilities and achievements of disabled individuals and of their need for full integration and participation in society—and to implement measures to fulfill those needs," said O'Flaherty.

ONE FAMILY

(Continued from page 27.)

photography to a current collection of fiddler crabs.

Charlie, who has spina bifida and brain damage, spent 10 years in an institution. He loves animals, and he is now in an environment where life brings some pleasure.

The little, dark-haired Maria, who was hit by a car, is one of three youngsters requiring total care.

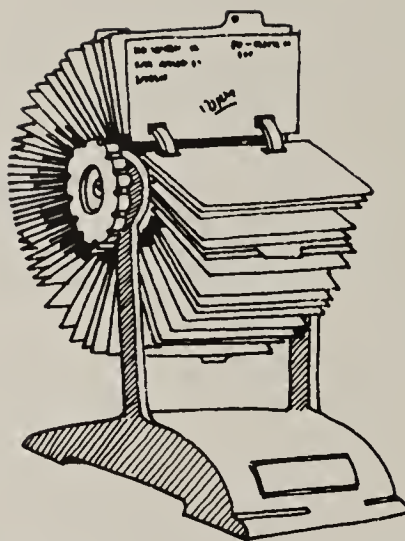
All of the children have gifts to share with the family. Rachel recounts "Simone's joy, Ellen's spontaneity, Dina's efforts to overcome her sorrow, Eddy's sensitivity, Robert's positiveness, Rachel Marie's creativity, Susan's radiance, David's humor, Patrick's cuddliness. . ."

If anything frightens this unflappable couple, it is the thought of having six 13-year-olds at once. If anything tries their patience, it is the question, "Which children are yours?"

What is unusual about tracking snow into the living room, pet ants, ferry rides on the bay, a five-day power outage, evening prayers, messy bedrooms, neighborhood kids borrowing the wheelchairs, and baking eight pies for Thanksgiving?

In that rural stretch of Connecticut, away from the stultifying language of theorists, a couple of people named Rachel and Carl rediscovered one of the keys to letting disabled people live and develop as human beings. They describe the work as "so ordinary, so simple." Maybe that's the reason, a cynic might say, the idea is so slow catching on elsewhere. Then again, it might be like the purloined letter—visible but not yet obvious.

Mr. Brubeck is the Public Information Officer, Administration on Development Disabilities, Department of Health and Human Services.



TOPIC OF STATE

(Continued from page 8.)

—*What's Happening*. California Department of Rehabilitation.

S.C. Training Accents Written Plan For Clients

The South Carolina Vocational Rehabilitation Department has completed a training program for personnel across the state in an effort to increase emphasis and expertise in the area of client vocational assessment and planning. This should result in more substantial rehabilitation services and more selective job placement. . . .

Realizing a need for some changes in the service delivery system, a task force of agency personnel, including staff from local areas and facilities, began to review possible changes. One major proposal was development of a revised Individualized Written Rehabilitation Program (IWRP).

. . . The new IWRP consolidates the evaluation summary and was developed in a format which would facilitate the counselor's use, thereby

providing additional time to be spent with clients.

By being better prepared to assess the vocational implications of handicapping conditions, the VR staff and the client can more realistically meet the agency's objective of more substantial services and more selective job placement for our handicapped citizens.

More than 300 employees were involved in the 3-day training. . . . As a result . . . counselors and evaluators should have expanded their skills in working with functional limitations and handicapping conditions.

—*New Horizons*. South Carolina Vocational Rehabilitation Department.

LANGUAGE

(Continued from page 24.)

hit albums. They drive two-door cars with instrument panels like an F-16's. They like High-Tech furniture, track lighting, glass, and brass. They actually go to plays in New York and follow professional sports. The down-filled men wear turtleneck sweaters and Gucci belts and loafers and cover parts of their ears with their hair. The down-filled women still wear cowl-necked sweaters and carry Louis Vuitton handbags. The down-filled people strip wood and have interior walls removed. They put on old clothes before the workmen come over. In the summer they like cabins on fresh water and they go hiking. They regard 'Saturday Night Live' and Steve Martin as funny. They say 'I hear you,' meaning 'I understand what you're saying.' They say 'Really,' meaning 'That's right.' When down-filled strangers are at a loss for words, they talk about real-estate prices."

IN THE SENATE OF THE UNITED STATES

Mr. DOLE (for himself, Mr. Hatfield, Mr. Randolph, Mr. Stafford, Mr. Moynihan
Mr. Baucus, Mr. Bentsen, and Mr. Heinz submitted the following concurrent
resolution; which was

CONCURRENT RESOLUTION

Expressing the sense of the Congress with respect to implementing the objectives of the International Year of Disabled Persons (1981).

Whereas a new era in recognition of human rights and universal respect for these rights has begun;

Whereas the United Nations General Assembly has declared 1981 as the International Year of Disabled Persons;

Whereas the United States has made great strides during the last decade in improving the lives of 35 million American citizens with physical and mental disabilities;

Whereas there is still much to be done to open doors for disabled persons;

Whereas the United States recognizes the need for further progress in strengthening public understanding and awareness of the needs and aspirations of disabled persons; and

Whereas the United States Council for the International Year of Disabled Persons is coordinating public and private participation during the International Year of Disabled Persons: Now therefore be it

Resolved by the Senate (the House of Representatives concurring),

That it is the sense of the Congress that the President should take all steps within his authority to implement, within the United States, the objectives of the International Year for Disabled Persons (1981), as proclaimed by the United Nations General Assembly Resolution 31/123 of December 16, 1976, as well as the goals of the Federal Interagency Committee which coordinates the activities for the International Year of Disabled Persons within the Federal Government.

Sec. 2. The Secretary of the Senate shall transmit a copy of this concurrent resolution to the President.

Official Business

ED 395

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MAY-JUNE 1981

AMERICAN REHABILITATION

Planning for the Future in Research

THE WHITE HOUSE

WASHINGTON

March 24, 1981

I welcome this opportunity to express my continuing high regard for the work of the World Rehabilitation Fund and to congratulate you on your twenty-fifth anniversary of service to mankind. In the finest American tradition, the Fund is dedicated to restoring mankind to productive and dignified lives. The Fund has long been in the forefront in the training of rehabilitation personnel in all parts of the world and in the interchange of rehabilitation experts and knowledge.

Not only has this advanced the cause and art of rehabilitation, but, equally important, it has brought about newer understanding among the peoples of the world. People differ in their customs and ideologies, but they are united in the quest for life free of the impediments of disability. Laboring in the truest spirit of humanitarianism, the World Rehabilitation Fund fills a great role in furthering the integration of disabled people into the mainstream of their societies. You have my best wishes for every future success.

Ronald Reagan

AMERICAN REHABILITATION

Volume 6, Number 5

The weakest ink is better than the strongest memory.

May-June 1981

2	Counselor Appraisal Systems	Daniel H. Averbek and Cary Perkins
10	Coming To Terms With Deafness	Carolyn Hyatt
15	Review: A Broader View	Chris Wood
18	Social Trends And Their Implications For Research	Betty Jo Berland and Richard Leclair
23	Which Way Is Program Headed?	Larry Mars
26	Special Education-Vocational Rehabilitation	Joseph Fenton, Ed.D., and Robert A. Keller, Jr.
31	Review: Handicapped Child In School	Edna Adler

DEPARTMENTS

14	Topic of State	24	NIHR
16	Notes On The Margin	Cov. III	Access America
22	IYDP		

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Counselor Appraisal Systems

Daniel H. Averbek and Cary Perkins

The Ohio Rehabilitation Services Commission conducted a national survey of counselor appraisal systems. Forty states and one territory responded, revealing a wide diversity of formats and procedures. Traditional trait rating scales were prevalent, particularly for agencies that are required to use a common form for all state employees regardless of their assigned duties (*i.e.*, Ohio). These formats typically focused on general worker traits, such as job knowledge and responsibility, which are rated by the employee's immediate supervisor.

Another common appraisal approach was management by objectives (MBO). The employee and supervisor jointly develop periodic performance goals which form the basis of future evaluations. Thus, MBO allows an individualized performance appraisal.

Other agencies have attempted the elimination of subjectivity through objective performance quotas. These appraisals rely on tallies of cases handled, completed rehabilitation plans, etc., for each counselor and their comparison with established quotas.

A less common approach involved actually rating the specific behaviors required for successful counselor performance. This system presupposes a detailed job analysis with very explicit task statements.

A great majority of the states used aspects of several evaluation techniques. A summary of each system is

provided in Tables 1 and 2. Included are breakdowns of the various types of scales (Table 1), uses of the appraisal information, specificity of the appraisal (Table 2), and other information relevant to each state's performance evaluation system. Each system has been categorized according to the information obtained in the survey request. To the extent that survey information was sketchy or incomplete, the contents of Tables 1 and 2 will likewise be less than comprehensive. However, to the best of our knowledge, their contents represent an accurate description of the material supplied through the survey. In some instances, several agencies from the same state (*i.e.*, division of blind services, department of vocational rehabilitation, etc.) responded individually to the survey request. Where substantial differences existed, separate breakdowns were provided.

Trait Ratings

As can be seen in Table 1, most agencies rely to some extent on trait ratings. There was substantial similarity among the states with respect to these traits. Table 3 presents a synthesis of the traits with their corresponding definitions and descriptions. In their original form, these definitions varied in the degree to which they were specific to the duties of a rehabilitation counselor. Some agencies described each trait in terms highly relevant to a counselor's position. Others preferred to explain each

trait in more general terms, thereby leaving it to the supervisor to adopt the descriptions to the counselor being evaluated. A careful reading of Table 3 will reveal both the generality and the specificity with which these traits were defined. The various traits could readily be grouped into six skill categories: general, personality, performance, process, interpersonal, and dedication. For the most part, the various agencies incorporated qualities from each category.

The formats by which the trait ratings were made were also highly similar across states. The typical structure consisted of a five to seven point scale with possible ratings from unsatisfactory to excellent. Several states used two separate forms, one for supervisory and one for nonsupervisory employees. These formats differed only in the traits being rated. The supervisory scale focused more extensively on leadership qualities.

Several recurrent problems were cited by users of trait approaches. Possibly the most predominant shortcoming is a lack of consistency (low reliability) among supervisors conducting the ratings. This relates specifically to inconsistent interpretation between supervisors regarding the meaning of scale adjectives, such as commendable, satisfactory, marginal. It appears that evidence of a trait which merits a "satisfactory" performance evaluation in the eyes of one supervisor may constitute only a

rating of "marginal" from another. This is particularly bothersome when performance appraisal data is used in wage and promotion determinations.

Several trait scales were also criticized as being too general for purposes of counselor development. General trait formats frequently failed to provide enough information for performance improvement. Some agencies attempted to overcome this by defining each individual trait in terms specifically relevant to the counselor's job. In these instances, employee reactions were reported to be more favorable than where global trait descriptions were used.

Concern was also expressed regarding the propensity for many supervisors to assign negative ratings even for counselors who are obviously performing poorly (often called leniency error).¹ This error artificially inflates performance evaluations, and, thus, presents problems when salary and promotion decisions are based on these data. Although frequently associated with trait formats, leniency error is also common in other appraisal systems. Supervisor training was recommended as a method of reducing its occurrence.²

Trait rating formats have the advantage of being relatively easy to complete in that minimal time and effort are required. In addition, where global traits are considered, the same scale can be applied across many diverse jobs. This was born out in the survey results which showed that many states using one standard rating scale for all jobs were committed to a trait rating system. Nevertheless, agencies using this approach were concerned that many global traits were not job relevant.

MBO Systems

Although somewhat less prevalent than trait ratings, MBO systems are

popular. Most of the MBO programs described in the survey incorporated a session during which counselor and immediate supervisor set performance objectives for the coming evaluation period. Six months to one year following objectives determination, they again meet to discuss progress toward objectives attainment. Frequently, performance is assessed with respect to those goals that have been accomplished, as well as those not achieved. New and/or updated objectives are usually established during each evaluation period.

MBO systems are advocated because they permit an individualized approach to performance appraisal. Specific work objectives are constructed that are specifically tailored to the developmental needs of each counselor. Due to the degree of participation and cooperation between counselor and supervisor, counselors react favorably to MBO.

Supervisors, however, express some criticisms. First, a greater time expenditure is required just to develop objectives. Second, considerable training is often required, particularly by supervisors, to ensure that they are properly skilled in the development of adequate and effective performance objectives. Finally, although the jointly created performance goals provide an excellent vehicle for counselor development, the individual nature of these objectives pose problems when performance appraisals are to be used for wage and promotion determinations. The lack of standard measure on which comparisons can be made between one counselor's performance and that of another is very pronounced when a strict MBO system is used.

In overcoming this problem, several states have combined MBO with a trait rating approach. The evaluation form typically includes a section de-

voted to the development and evaluation of three or four individualized performance objectives followed by several common traits on which all counselors were rated. Thus, the individualized performance objectives aid in counselor development while the standard trait ratings permit greater differentiation among the counselors that is necessary for personnel decisions. Frequently, the supervisor is also required to make one overall rating of each counselor's performance, thereby permitting further comparison among counselors.

Behavioral Ratings

Somewhat similar to MBO, yet not as popular among rehabilitation agencies, is a behavioral rating approach. In developing these systems, a thorough job analysis results in numerous task statements that describe important job aspects. Performance standards for each task are established and become the basis of evaluations. Supervisors are required to indicate the percentage of time a given counselor meets each performance standard. An alternative rating procedure requires the supervisor to simply indicate whether a counselor performs below, at, or above standard on the various tasks.

Relatively few states use this system. The specific nature of the work performance standards allows for more objective ratings (subject to fewer misinterpretations) than does the trait rating method.³ Also, the behavioral ratings, by their very nature, provide each counselor with specific performance feedback. Thus the system is an excellent developmental tool in that the evaluation itself specifies what the counselor must do to improve performance. In addition, behavioral ratings circumvent some of the problems associated with pure MBO approaches. Because the 3

Table 1

Summary of Appraisal Information Obtained from
Rehabilitation Agencies Responding to the
Performance Evaluation Survey

State	Type of Evaluation				Purpose of Evaluation			
	Trait Ratings	MBO/ Goal Setting	Behavior Ratings	Objective Standards	Counselor Development	Wages & Salary	Promotion/ Termination	Layoff
Alabama	X				X			
Alaska	X				X	X	X	
Arkansas		X			X	X	X	
California				X			X	
Connecticut	X			X		X	X	
Delaware	X				X	X	X	X
Florida								
Blind Services	X	X		X	X	X	X	X
Voc. Rehab.	X	X			X	X	X	X
Hawaii	X			X				
Idaho	X	X			X	X	X	X
Illinois	X	X			X	X	X	
Kansas	X				X		X	
Kentucky	X				X			
Louisiana	X			X	X	X	X	X
Maine	X			X	X	X		
Massachusetts								
Blind Services	X				X			
Voc. Rehab.	X	X			X			
Michigan								
Blind Services			X		X			
Voc. Rehab.		X		X	X			
Minnesota				X	X			
Mississippi								
Blind Services				X				
Voc. Rehab.	X	X			X	X		
Missouri	X	X			X			
Montana	X				X		X	
Nebraska	X				X	X	X	
Nevada		X	X	X	X	X	X	
New Jersey			X	X	X	X	X	X
New York				X	X	X		
North Carolina		X			X	X	X	
Ohio	X				X		X	X
Oklahoma	X				X	X	X	
Oregon			X	X	X	X	X	X
Pennsylvania	X			X	X		X	
Puerto Rico	X				X	X	X	
Rhode Island	X							
South Carolina								
Blind Services	X				X	X	X	
Voc. Rehab.	X							
Tennessee								
Blind Services	X							
Voc. Rehab.	X	X			X	X	X	
Texas					X	X	X	
Utah	X			X	X	X	X	
Vermont			X		X			
Virginia	X	X			X	X	X	
Washington	X			X	X			
West Virginia	X	X			X			
Wisconsin		X			X			
Wyoming		X	X		X			

Table 2

Summary of Appraisal Information Obtained from
Rehabilitation Agencies Responding to the
Performance Evaluation Survey

State	Specificity of Evaluation		Rater		Miscellaneous			Ratings = R Narrative = N
	Common Format All Positions	Specific Counselor Format	Supervisor Ratings	Self- Ratings	Frequency Of Evaluation	Appraisal Interview	Appraisal Manual	
Alabama	X		X		ANNUAL	X		R
Alaska	X		X		ANNUAL	X	X	N & R
Arkansas		X	X		ANNUAL	X	X	N & R
California		X	X		ANNUAL		X	R
Connecticut	X	X	X		ANNUAL	X		R
Delaware	X		X		ANNUAL	X		R
Florida								
Blind Services	X	X	X	X	ANNUAL	X	X	R & N
Voc. Rehab.	X	X	X		ANNUAL	X	X	R & N
Hawaii	X	X	X		ANNUAL			R
Idaho	X	X	X		ANNUAL	X		R & N
Illinois	X	X	X	X	ANNUAL	X	X	R & N
Kansas	X		X		ANNUAL	X		R & N
Kentucky	X		X	X	ANNUAL	X		R & N
Louisiana	X		X		ANNUAL	X		R & N
Maine	X	X	X		ANNUAL	X		R
Massachusetts								
Blind Services	X		X		ANNUAL	X		R & N
Voc. Rehab.	X	X	X		ANNUAL	X		R & N
Michigan								
Blind Services	X		X		SEMI-ANNUAL			N
Voc. Rehab.		X	X	X	SEMI-ANNUAL	X	X	N
Minnesota		X	X			X		R & N
Mississippi								
Blind Services		X	X		ANNUAL			
Voc. Rehab.	X		X	X	ANNUAL	X		R
Missouri	X	X	X		ANNUAL	X		R & N
Montana	X		X		ANNUAL	X	X	R & N
Nebraska	X	X	X		ANNUAL		X	R & N
Nevada		X	X		ANNUAL	X	X	R & N
New Jersey		X	X		SEMI-ANNUAL	X	X	R & N
New York		X	X		ANNUAL	X		R & N
North Carolina		X	X		SEMI-ANNUAL	X	X	N
Ohio	X		X		ANNUAL	X		R
Oklahoma	X		X			X	X	R & N
Oregon		X	X		ANNUAL	X		N
Pennsylvania	X		X		ANNUAL	X	X	R & N
Puerto Rico	X							
Rhode Island	X		X		ONLY DURING PROBATION			R
South Carolina								
Blind Services	X		X		ANNUAL	X	X	R & N
Voc. Rehab.	X		X		ANNUAL	X		R & N
Tennessee								
Blind Services	X		X		ANNUAL			R
Voc. Rehab.	X		X		ANNUAL	X	X	R & N
Texas	X		X		ANNUAL	X		N
Utah	X		X		ANNUAL	X	X	R & N
Vermont		X	X		ANNUAL			R & N
Virginia		X	X		ANNUAL		X	R & N
Washington	X		X	X	ANNUAL	X	X	R & N
West Virginia	X		X		ANNUAL			R
Wisconsin		X	X	X	ANNUAL	X	X	N
Wyoming		X	X		QUARTERLY	X		N

same work performance standards hold for all counselors, behavioral rating systems permit direct comparisons between counselors in wage and promotion considerations. Therefore, unlike MBO, a trait rating system need not be included to facilitate differentiation among counselors when behavioral ratings are used.

Despite these advantages and favorable reports, it is interesting to speculate why so few agencies have chosen this form of performance appraisal. The numerous task statements which require individual ratings by a supervisor dramatically increase the time necessary to complete each evaluation. One state whose behavioral rating system included 116 separate items noted that the format was particularly burdensome for the supervisors, despite favorable attitudes toward the system by the counselors. Furthermore, the initial development of the system requires the expenditure of considerable effort in developing task statements which themselves must be periodically up-dated to remain current with changes in counselor functions. These factors may likely prohibit many states from constructing behavioral rating systems.

Objective Standards

In an effort to eliminate the many problems encountered with supervisor ratings, some agencies have chosen to bypass ratings altogether. Statistical documentation of the number of referrals received, number of placements made, etc. form the basis of objective standard appraisal systems. These data are then compared to predetermined cutoffs thought to be necessary for adequate counselor performance. Advocates of the objective standard system have noted a reduction in the time required to complete performance appraisals. In fact, it has
6 been possible to computerize much of

the process, thereby also eliminating any supervisory biases or misinterpretations. However, objective appraisals have been criticized for their failure to consider the many dynamic aspects of a counselor's duties. Particularly, objective evaluations are insensitive to aspects of the job that are beyond the counselor's control (*i.e.*, case load difficulties). In addition, the "by the numbers" nature of the system makes it of little value in the area of counselor development.

Purpose of Appraisals

As indicated in Table 1, the most predominant purpose for collecting appraisal data is counselor development. Several states appear to use performance appraisal solely for this purpose. As expected, wage and salary determination, as well as promotion and termination decisions, are also frequently based on performance evaluations. Considerations for possible layoffs, however, are only rarely made on the basis of appraisal data.

Specificity of Evaluation

This section of Table 2 refers to an agency's use of one common format (typically mandated by state policy) on which all employees (regardless of their job responsibilities) must be evaluated. Agencies using such a format have been so indicated in the column marked "common format all positions" (see Table 1).

Some agencies reported the development of appraisal formats specifically applicable to the rehabilitation counselor's position. Under this system, each counselor is evaluated on behaviors and/or traits that are particularly relevant to effectuate performance as a rehabilitation counselor. As indicated previously, many state rehabilitation agencies have adopted an appraisal procedure that incorporates both trait ratings and goal setting, as

well as objective performance standards. Within these agencies, it is common practice to use a trait rating format that is standard for all employees, regardless of their job responsibilities. On the other hand, goals established through an MBO procedure or objective performance standards (such as the number of closed cases, etc.) are purposely designed to be job specific and relevant to the counselor's duties.

Rater

Virtually all the agencies responding to the survey indicated that the counselor's immediate supervisor held the primary responsibility for completing performance appraisals. Only rarely was a counselor permitted to formally evaluate his performance. Kentucky, Illinois, and Mississippi require that the counselor provide a self-rating on the same traits which are rated by the supervisor. Differences between self and supervisor ratings then form the basis for discussion in performance appraisal interviews.

In addition to conducting self-ratings, the State of Washington also invites the employee to write additional comments in support of his self-ratings. Tennessee also permits some employee input into performance ratings; however, instead of a self-rating, the counselor is simply asked whether he agrees or disagrees with each supervisory rating.

Although not specifically indicated in Table 2, most agencies using an MBO approach permit and encourage employee participation in setting work objectives, as well as in assessing their attainment of these objectives. This self-assessment in the MBO format generally takes the form of verbal input by the counselor during developmental sessions with the supervisor.

Additional Information

Most agencies appear to conduct appraisals annually, with several preferring semi-annual evaluations, and one with a quarterly evaluation system. Generally, evaluations are conducted more frequently when an employee is on probation.

A performance appraisal interview is common among most agencies. We believe that even in agencies which did not specifically mention their performance appraisal interview, some type of evaluation interview takes place. An interview is almost a necessity for those agencies employing effective MBO systems. However, it is possible sometimes to skirt the frequently uncomfortable appraisal interview when only trait ratings are used. To ensure that the interview is conducted, many agencies require that the counselor sign the rating form acknowledging the supervisor's ratings.

Associated with the performance appraisal interview, some agencies issue a guide manual to supervisors suggesting approaches to conducting evaluation interviews and completing the form itself. The manuals vary in content.

In agencies that use MBO and/or performance standards, guidelines are suggested for developing adequate performance standards. When trait rating scales are used, detailed descriptions and definitions of each trait are often included in the manual, in addition to explanations of the various scale categories (see Table 3). These definitions reduce misinterpretations of the scale categories and traits by increasing the consistency of supervisory ratings.

Some agencies (*i.e.*, Alaska and Tennessee) also present detailed guidelines for planning and conducting performance appraisal inter-

views. Effective techniques for putting the employee at ease, questioning strategies, problem solving, summarizing information, etc. are discussed. Other agencies forego the rater's manual and opt, instead, for a brief memorandum describing the appraisal process. Still others offer no additional guidelines, other than the instructions contained on the evaluation form itself.

The majority of agencies incorporate both a simple rating and a narrative report in their evaluation procedures. Frequently, the opportunity is provided for giving a narrative comment to justify a particular rating. When the rating is especially positive or negative, a narrative statement is often mandatory. Texas uses a unique system that is completely narrative and open-ended. No particular dimensions or traits are outlined, rather the supervisor is asked to describe the employee's strengths, areas of needed improvement, and specific achievements.

Other agencies employing a narrative approach (Wyoming, Michigan, and Pennsylvania) generally indicate specific criteria to be included in the assessment comments. Finally, several states (Wisconsin and North Carolina) employing an MBO approach require narrative comments describing the degree to which various performance goals have been attained.

Conclusions

Generally, agencies were dissatisfied with current performance systems. This was particularly true of those agencies using the one standard trait rating approach for counselors and other employees alike. Many agencies in this situation were contemplating or were actually developing alternative evaluation procedures. All too often, however, some departments, despite acknowledging

the shortcomings of their evaluation approach, were powerless to institute any significant changes due to statewide personnel policy, labor contracts, and other constraints.

Agencies fortunate enough to have some autonomy typically constructed new systems to assess performances specific to counselor's job duties. In this respect, it was common to incorporate some form of MBO. As shown in Table 1, many agencies opted to include MBO with a statewide, mandatory trait evaluation scale.

Of the few agencies that expressed satisfaction with their appraisal format, the majority was highly counselor specific. Thorough job analyses had been conducted that resulted in clear, behavioral task statements that described the duties of a rehabilitation counselor. The counselors themselves seemed to prefer evaluations based on these behavioral statements because of the highly specific feedback inherent in the system. The specific nature of the feedback gave the counselor a clear picture of exactly what had to be done to improve performance.

Unfortunately, few agencies have been able to implement appraisal systems of this kind due to constraints beyond their control (*i.e.*, contracts, state policy, etc.). Under these circumstances, several options are available. It may be feasible to develop a supplemental system to be used in conjunction with any state mandated evaluation form. This supplemental system (*i.e.*, MBO, goal setting, behavior ratings, etc.) could be used primarily for counselor development, while the more formalized, statewide appraisal format remains for personnel and salary decisions.

However, many departments overlook the fact that even a mediocre appraisal system can be made more effective by training those people who

make the appraisals.⁴ The frequently mentioned problems of inconsistency (unreliability) and leniency can become the focus of training, thereby underlining the importance of avoiding these errors.

The greater the emphasis on accurate and fair performance appraisals, the more useful any evaluation system is likely to be. Even the most carefully designed appraisal format can fall victim to evaluation errors when a lax attitude is allowed to develop.

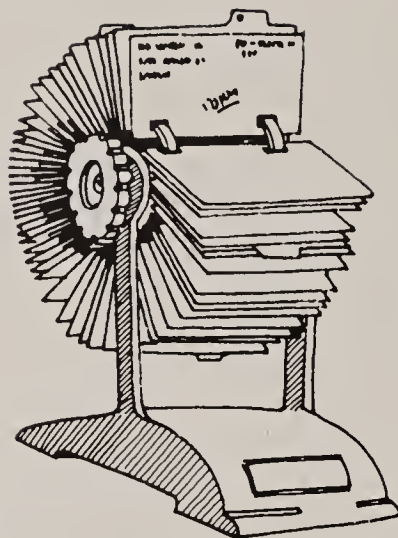
The construction of performance appraisal manuals is another step toward fostering care and concern in making performance appraisals.

The results of this survey serve to underscore the fact that, while the evaluation systems are far from ideal, efforts other than developing totally new formats (*i.e.*, rater training, appraisal manuals, supplementary MBO, etc.) can improve the accuracy and effectiveness of current appraisal systems.

Mr. Averbeck is research associate and Mr. Perkins is Chief, Division of Personnel Administration, Ohio Rehabilitation Services Commission.

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Table 3

Common traits and their corresponding descriptions used in the evaluation of rehabilitation counselors.

1. GENERAL

A. Attendance & Punctuality: Faithful in coming to work daily, conforms to scheduled working hours; maintains good attendance record; reports absences and tardiness in advance.

B. Personal Appearance: Neat, makes a good impression to the public; clothes are clean and in good taste; maintains a well groomed and poised image.

C. Dependability: Conveys to others that one can be counted on to perform assigned tasks satisfactorily and to completion; trustworthy; is conscientious in observing office rules and procedures, follows through on promises made to clients and co-workers.

2. PERSONALITY

A. Attitude: Strives to do an excellent job; seeks to attain goals and im-

prove job performance; demonstrates energy, enthusiasm, originality, and imagination in handling job duties; takes difficulty in stride.

B. Initiative: Self-starting action; displays self-reliant enterprise; works without prodding; demonstrates a willingness to make necessary decisions; generates constructive ideas; inventive; integrates ideas in developing new ways of doing things; is sensitive to operating efficiency and cost cutting.

C. Insight: Is able to see through facades and grasp the truth of the matter; formulates case plans that take into account the needs and wishes of the client; innovative and creative in handling novel situations.

D. Responsibility: Completes necessary tasks successfully without requiring close supervision; freely admits one's own mistakes rather than "passing the buck;" is receptive to constructive analysis and guidance aimed at bettering competence.

3. PERFORMANCE

A. Quantity: Completes an acceptable amount of work on time; is a high producer; when working with others, will do his/her share of the project; remains up-to-date in processing case work, making contacts, rendering services, and maintaining intake.

B. Quality: Produces accurate, high quality work; possesses high standards; is attentive to details; work can be relied on; checks own work; work is neat and free of errors.

C. Utilization of Time: Applies time, energy, and interest in an effective manner including proper attention to and prompt completion of other assigned work; efficient management of caseload; effectively schedules appointments.

D. Job Knowledge: Is knowledgeable of agency policies and proce-

dures; displays adequate skills and experience to do the job, such as counseling, guidance, vocational assessment, job placement, knowledge of disabilities; aware of community resources; well informed concerning Title II and Title XVI of the Social Security Act; familiar with job market trends; displays proper use of the DOT; adequate understanding of physical, psychological, and occupational factors relevant to rehabilitation.

E. Performance Under Stress: Maintains the quality and quantity of one's work in spite of the emotional pressures encountered on the job (i.e. crisis situations, verbal abuse from clients); monitors one's own feelings and does not permit prejudices to interfere with one's work; avoids becoming overly involved in relationships with clients; remains honest about one's failures and copes effectively with setbacks.

4. PROCESS

A. Ability to Learn: Understands and follows instructions; can comprehend new approaches and methods; applies new ideas appropriately; has good memory skills; seeks and accepts training; grasps abstract ideas and concepts.

B. Acceptance of Change: Adaptable and flexible; adjusts satisfactorily to new work surroundings, new procedures, new co-workers, and new supervisors.

C. Decision Making: Actions are based on sound reasoning; obtains and analyzes facts; anticipates needs and foresees possible consequences of recommendations; consistent and reliable in his/her judgments; consults with higher levels of authority where appropriate before making commitments; communicates confidential information only to authorized individuals with a legitimate need to know;

Appointment

President Ronald Reagan has recently appointed Mrs. Virginia Knauer to be Special Assistant to the President, directing the Office of Public Liaison.

In this capacity, Mrs. Knauer will deal with, among others, disabled Americans, consumer affairs, health care, safety, etc. She is a well known and highly competent expert in these matters, having held a similar post in the administrations of both Presidents Nixon and Ford.

makes appropriate determinations concerning social security Title II and Title XVI claims.

D. Leadership: Inspires teamwork and productivity; stimulates suggestions; creates positive and optimistic attitudes through tact rather than power and coercion.

E. Management Skills: Establishes levels of priority and shifts priorities where necessary; follows rules, regulations, and prescribed procedures carefully; acts in accordance with the spirit of the regulations in situations not specifically covered by the usual guidelines; fills out forms and performs computations accurately; distributes work to secretaries in a timely and orderly manner.

F. Problem Solving: Recognizes and resolves real and/or anticipated barriers to achieving planned accomplishments; seeks out pertinent data to logically reach workable solutions; applies knowledge and skills to new situations.

5. INTERPERSONAL

A. Communications: Understands and takes proper action with respect to oral and written communications received; writes clear and effective memos and correspondence; commu-

nicates information effectively to co-workers, supervisors, clients, and the general public.

B. Human Relations: Open and cooperative with peers, clients, and the public; quickly establishes rapport with clients and other disciplines; shows courtesy, respect, and consideration for others encountered on the job; uses tact and diplomacy in his/her dealings with others; shares information with clients in a sensitive manner; practices professional ethics in all relationships; works harmoniously with co-workers; creates a favorable impression of the organization.

C. Relationship With Supervisor: Reacts to supervision in a positive constructive manner; keeps supervisor informed of important developments; participates freely in individual and staff conferences; shares responsibility with supervisor; asks for help when appropriate, but not to excess.

6. DEDICATION

A. Commitment To Clients: Demonstrates a willingness to go out of the way to help clients; perseveres in one's effort on behalf of clients in spite of setbacks; accepts the responsibility to act on behalf of clients even when this entails "going out on a limb;" works extra hours for the sake of clients.

B. Commitment To Organization: Identifies with the goals and missions of the organization; invests one's energy in trying to improve the working procedures of the organization; participates in work related community activities on one's own initiative.

C. Employee Development: Seeks out opportunities and expends extra effort to improve self; reads job related literature; participates in additional training for professional improvement; participates in related professional organizations.

Coming To Terms With Deafness



Carolyn Hyatt

DRIFTWOOD

Here in my little room I sit alone,
Passing the long hours of the day.
I sit upon my worn bed and think;
But my thoughts are far away.

Often I wonder why I am here,
What is the purpose of this lonely life,
And is there any reason to go on;
Continue to endure the sorrow and the strife?

The happiness of life eludes my grasp
When I try to sample its sweet taste;
I have so much, yet something in it lacks,
And I feel my lonely life's a waste.

Like a piece of driftwood tossed at sea,
I do not know where I will finally land;
Life is cold and uncaring like the waves—
I often long for but one friendly hand.

I wrote the above poem when I was 21, little realizing that 6 years later there would be, not one, but many "friendly hands." They had been there all along, waiting to unlock the lonely, silent barrier of deafness. But I did not know sign language or other deaf people when I composed *Driftwood*.

When the measles, mumps, and chicken pox teamed up to destroy most of my hearing at age seven, leaving me with a 92 db loss in both ears, I simply continued to attend public school. At the time, I was in first grade. I don't remember being aware of my newly imposed silence barrier, however, until the next year.

The first hint that things were different came in my second grade class one morning when the teacher was demonstrating how sound travels. She moved from desk to desk, placing one end of a yardstick at each child's ear and a large stop watch at the other end. When it was my turn I pretended to be as excited as the others, nodding as if I, too,

heard the ticking. In reality there was only silence.

Without being aware of it, I had begun to lipread after my illnesses. This seems to have allowed my hearing loss to escape detection for a time. But some of my grades suffered. I can recall straining to catch single words on my teacher's lips in third grade when she gave the weekly spelling test. I knew how to spell most of the words, but had to leave many blank spaces in the paper because I couldn't catch them from her mouth movements, even though I sat in the front row.

In fourth, fifth, and six grades, my teachers had another child give me the spelling tests alone in the back of the room. If I couldn't lipread the word, they would draw a picture of what it represented, write a sentence with a blank space for the word, or use other hints to help me complete the test.

Unfortunately, the same process was not used for arithmetic or math, and these remain my worst subjects. I could

see the teachers write figures and problems on the board, but missed all the explanations of how to arrive at the correct answer. I tried to learn from the books by myself, but they were, for the most part, just as confusing.

Surprisingly, no one mentioned the possibility of my attending a school for the deaf until I was 14 and a freshman in high school. Before that I was just treated as any other kid, receiving no special help except for the spelling tests and a limited amount of speech therapy in the fourth and fifth grades with a few other children, all of whom had normal hearing. For the most part, I depended on the written word for information both in and out of classes. Sometimes teachers wrote assignments on the blackboard or handed out ditto sheets. If they just told us what to do orally, I could rarely understand what was said, even though I'm considered a good lipreader. I had to depend on other children to tell me what we were supposed to do.

I had always loved to read, and after I became deaf I read even more. Reading, writing, and English were my best subjects in school. I'd read anything I could get my hands on. The daily paper became "must" read material for me by the age of 10 or 11. I started with the comic pages and by the time I was about 13 I went through the whole thing every day. I also enjoyed books like the Nancy Drew Mysteries, the Bobsey Twins, the Hardy Boys, Timber Trail Riders, and classic such as Tom Sawyer, Rebecca of Sunnybrook Farm, and Two Years Before the Mast. I started buying books to read and keep when I was in elementary school. Now I have well over 1000, and my collection is still growing. Reading helps me increase my knowledge and stay in touch with the world and provides many hours of pleasure.

But books can never replace human companionship. I was very lonely dur- 11

ing my school years, all the way through college. In elementary and junior high school I had one or two friends each to play and talk with. But I still spent a lot of time alone. The loss of my hearing seemed to bring on a loss of friends also. My high school and college years were even worse; I was socially isolated. This changed only when I went to Gallaudet College to start work on my MA degree.

What was it like to a deaf child in public school? Let me give an example, though it must be remembered that my experiences may be different from others.

One day, in the sixth grade, my class went outside to play a game. Everyone sat down in a circle. A child started the game by whispering something to the youngster next to her. He whispered it in the ear of the next child, and so on around the circle, until they came to me. I tried as hard as I could to hear what was being whispered in my ear, but the words were only puffs of air. How could I pass them on? I tried to do so by whispering what I thought they might have been. That was a mistake. The child repeated aloud what I had said (which was just as meaningless to him as the whispered words had been to me, since I passed it on as I "heard" it), and the whole class burst out laughing at me.

I was made to move back out of the circle and watch as the game resumed without me. It was all I could do to keep from crying, but I didn't want anyone to see how much it hurt to be excluded; I had the pain behind a smile instead.

I wish I could say that this incident was just an isolated occurrence, but it is unfortunately something that happened often. As the years went on, I began to withdraw and tried to keep from being hurt by avoiding people as much as possible. I had always loved animals



The photo of the author and her "friend" on page 10 is by Liz Hammett and the photo above is by Gerry Gillespie.

sort. Now I began to look upon these pets as substitutes for the friends I so desperately wanted. I got my first horse when I was 13 and spent all of my time out of school either riding or reading. I was never without a horse after that until I sold my last one in order to pursue a master's degree at Gallaudet when I was 27.

Deafness can be a very socially isolating condition. This became more apparent in high school and college (excepting Gallaudet). The teen years were the hardest. As far as I knew at that time, I was the only deaf person around. I had never met anyone else who couldn't hear. I'd often watch the other kids talking and laughing together in high school. I read about football games, pep rallies, and dances in the school paper. I longed to be a part of that, but never was. Most of the other students avoided me, and I didn't know how to break into their social life.

Academically I did fine, except for math. I received no extra help or special attention in any class. It was still impossible to lipread the teachers, so I had to ask other pupils to tell me what to do. Sometimes the instructors also

wrote assignments on the board or passed out instruction papers. Once in a while a teacher would give me a written note, but for the most part I was left to my own devices.

When I started high school at 14, it was thought that I could not keep up with the others because of my hearing loss. After a few weeks, I was called into the office for a conference with the principal, school nurse, my teachers, and counselor. My mother was also present. They wanted me to attend a school for the deaf in Santa Ana, California, about 18 miles from my home. This was the first time anything had been said about my deafness in all the years since I lost my hearing at age seven. I wasn't happy about discussing it then, either.

I told them I did not want to go to the other school because the one I was presently attending was the only one offering classes in agriculture, and I wanted to major in that field. After much discussion, a decision was made to allow me to stay; on the condition that I obtain a hearing aid. My mother promptly took me to the nearest hearing aid dealer. He sold us a pair built into

eyeglass frames, showed me how to turn them on and off, then sent us on our way. No one told me how to adjust to the sudden influx of sound. I took an instant dislike to the instruments, wore them as little possible, and finally threw the whole thing away in a trash can at school.

Surprisingly, no one asked me what became of my old glasses when I told my parents I needed new ones. None of the people at school seemed to notice that I had discarded the required hearing aid so soon. I continued to attend that high school until I graduated—on the honor roll—without having heard a single word spoken.

After graduation, I attended California State Polytechnic College for a year, dropped out, worked in a lawn sprinkler factory for two years, then started college again at a local community college. I majored in journalism, was named as one of 25 "Women of Distinction," and graduated with honors. A transfer to California State University at Fullerton followed, where I completed work in my BA in communications, graduating, again with honors, in 1978.

I spent the next year vainly searching for a job where I could use my writing, photography, and public relations skills. Though many people seemed interested, I was always turned down because "You'd have to talk with customers," "You have to use the phone," or some other reason based on my inability to hear. As time wore on, I became increasingly frustrated.

I had started speech therapy at Loma Linda University in Riverside just before graduation from CSUF, and Louise, my therapist, was aware of my vain attempts to find a job. She also noticed my growing depression from repeated rejection and suggested that I see a deaf psychologist.

I agreed, somewhat apprehensively, never having spoken with a deaf person

before. How do you talk to someone who can't hear you? I began to feel as other people must have felt when they attempted to communicate with me. It turned out that he both spoke and used sign language. I couldn't understand the signs, but he was easy to lipread. The signs made me uncomfortable. I had been told years before by an audiologist that I should never learn sign language. He said that if I did, I would stop talking. He needn't have worried. I had no intention of advertising the fact that I was deaf. I wanted to be as much like hearing people as possible and often pretended that I heard a sound when others did.

But as time went on and I continued to talk with this deaf man, I began to consider learning sign language. I also began to accept, for the first time in my life, the fact that I was deaf. I had been denying it almost from the start because of the unspoken implication that deafness was "bad" in some way; meaning I must be a "bad" person. "Deaf" to me was a four-letter word, and I never used it in referring to myself.

I volunteered at the California School for the Deaf in Riverside as a teacher's aide and assistant to the school psychologist and started a sign language class at Riverside College. I also applied for admission to Gallaudet's Graduate Program in Counseling after the deaf psychologist told me about it. He had attended Gallaudet himself many years ago.

When I finally received word that I had been accepted at Gallaudet, I was very excited—and scared. For the first time since I became deaf at age seven I would go to school with other deaf people.

I arrived at Gallaudet in the fall of 1979. What a difference! Even though I did not know enough signs to follow complete lectures, I began to catch words or phrases here and there. I met many people, hearing and deaf, who

included me in their conversations, plans, and games. I was not left to sit bored and uncomprehending through lectures while someone else told me what we were supposed to do. I was not excluded from discussions or made to feel invisible as others engaged in lively conversations and debates around me.

For the first time in 20 years I felt like a real person again. The chains of silence had been broken, and I was free. I could communicate. I loved it. I still do.

Ms Hyatt is a graduate student in the Department of Counseling, Gallaudet College. She and Dr. McKay Vernon authored last issue's article, *Dorsey: Symbol of the Urban Deaf Condition*.

This article first appeared in *Gallaudet Today*, and it is reprinted with the editor's permission.

SIGNS

What is this?

They warned me about it,

As if it were a dangerous beast.

If I dared approach

And accept its friendly overtures

It would snatch my tongue—

They warned . . .

DANGER!! Stay away!!

Don't feed the beast,

Or even look at it!

But I have touched,

And looked, and learned to love;

For it is not a beast.

But instead is a liberating prince,

Responding to my tentative kiss

With grants of freedom and acceptance

This language of the hands,

Scorned, rejected, and vilified,

Has broken the chains of silence. 13

TOPIC OF STATE

Job Tryouts A Success In Wisconsin

If you're a client of DVR in the Wisconsin's Fond du Lac area, you could "tryout" a job as a bartender, a transmission specialist, a program aide in a rehabilitation facility, a teacher's aide, an engineer or a store clerk, to mention a few. Through the combined effort of DVR and Moraine Park Technical Institute, a bank of over 80 job sites can be chosen from.

"It's all part of an effort to help clients get real work experience, not only on one job, but a variety of jobs," states Dyana Fox, program coordinator. "Many of these people are either high school students or people who have been in long-term treatment programs, and have had little or no work experience."

Fox states that counselors were hesitant to use the program in its early days. "Ole Brekke, John Biddick, and Marty Eft were instrumental in the program becoming a reality," she continues. (Her salary is paid by the technical institute and office space and clerical support are provided by DVR.) "In the beginning, the counselors gave me old cases, social security and Workers' Compensation clients—a variety of the more difficult cases. The turning point came when they saw that I had real success with these different cases, and ended up with job placements for a number of them."

"The employers find benefits in the program, too" she continues. "It gives them a chance to serve their community in a meaningful way."

The school system, normally serving people only until the age of 18, now can work with people beyond the age cutoff through this program.

Ellen, serving as a teacher's aide in an area class for children with special needs, has found her experience valuable. In between lessons with individual students, Ellen takes time to talk about the placement. "I've only imagined what work is like," she says. "Now I've learned that patience is the most important thing to have on a job. It's easy to get frustrated, especially in this type of work. I've always received, and now I have a chance to give." She says she has more confidence in herself now, and knows that she can accomplish a goal once she's set her mind to it. "Until now, I had never relied on myself as a person. I've learned that I have a right to an opinion."

Ellen, who attended UW-White-water for a time, became interested in the field of speech pathology early in her school years. But she says it wasn't until this work experience that she realized how important this type of work is. She especially enjoys the one-to-one relationships she has established with her students. Ellen has muscular dystrophy.

The principal of the school speaks warmly of Ellen, and says that the extra help is much appreciated since it allows more time of individual instruction for the students.

Dave, disabled by a back injury, had been out of work for 3 years. He now works with a small engine repair business, and is paid for his experience. He convinced the owner to participate in an on-the-job training program. "It's beautiful," he says, "to be back at work again—and the boss, Roger, lets me work on whatever I want." Dave believes that his experiences in the Navy (boiler tender, stockkeeper, truck driver and ship-

ping and receiving clerk) have given him skills he can use on this job.

An important part of the work experience program is the pre-placement testing and individualized career exploration. Ongoing evaluation of the client on the work site is an integral part of the program.

Paul Monzel, Supervisor of the Fond du Lac DVR office, attributes most of the program's success to Dyana Fox. "She's excellent with the community, the employers," he states. "She works well with the clients and understands their needs and perspectives. And, she's really shown the counselors in my office just how effective she can be. They're very happy with her work."

Karen's present work experience is at a Kentucky Fried Chicken outlet. The manager says it's good to be able to help someone. Karen is learning all aspects of the business, from baking and dishwashing to serving customers.

Dyana emphasizes the need for sound assessment materials and programming. (She uses the McNight career inventories as part of her evaluation procedures.) She says, "If we can get people into a job they really like, they'll show more initiative." Hobbies, studies, and previous work experience are all factors to be considered when seeking a work site for a client.

Some of Dyana's other clients are "working" as an architect, a meteorologist, a stained glass artist, and an EMT trainee with a fire department.

A displaced homemaker with LPN training was offered a job after my 20 hours on a job career exploration placement.

"There's no better way to restore self-confidence than to get a job offer," muses Dyana.

—DVR Newsletter, Wisconsin Division of Vocational Rehabilitation.

Review: A Broader View

Chris Wood

Role of the Family In The Rehabilitation of the Physically Disabled. Paul W. Power and Arthur E. Dell Orto, editors. University Park Press, Baltimore, Maryland 21202. 1980. \$19.95, 554 pages.

Many of today's social observers decry the declining structure of the American family. Politicians call for government policies to strengthen the family while advocates of change call for new family forms. What is best for today's family? As the recent White House Conference on Families demonstrated, there are many different responses to this question. Power and Dell Orto are two rehabilitation educators who accurately recognize that, despite its current beleaguered status, the family can be a vital resource in rehabilitation.

Directed to all allied health professionals, this book describes the types of effective interventions which, indeed, can mobilize family resources toward rehabilitation goals. The goal is the rehabilitation of a disabled family member, but everyone in the family has something to gain. This attractive end is not easily realized by practitioners. It cannot be accomplished without a thorough understanding of the dynamics of families with disabled members. Development of such an understanding is the objective and theme of this comprehensive new source.

Disabled persons, Jackie, Joe, and others, and the parents of disabled children like Maria tell their stories and this is where it all begins. Interspersed

throughout the text, these human voices call out to the reader between original presentations by the editors and carefully chosen articles on family theory, research, and practice. This structure creates a highly successful and unique blend in the text.

The personal statements, highlighted in the text with larger print, involve the reader in the most natural way; one human being's concern and fascination with another. The editors offer concise, conceptual frameworks which serve as introductions to, and condensations of, the vast collection of materials assembled for this volume. It is helpful to return to these frameworks after reading sections in the text. The articles themselves come from a variety of sources and from a variety of practitioners in the rehabilitation field. They will open up new worlds of considerations for many readers, even experienced practitioners.

The interactional perspective and systems theory are the foundations upon which many of the authors build their work. They present refreshing and challenging new analyses of disability in the context of the family. Clara Livsey develops the system view in "Physical Illness and Family Dynamics." Yen Peterson provides a recent literature review on "The Impact of Physical Disability on Marital Adjustment." Specific disability situations and characteristic response patterns are also illustrated in articles such as, "Family Response to Traumatic Head Injury" by Mary D. Romano. Recom-

mended reading lists are provided at the close of sections so the reader can further explore some of these new topics.

When one adopts this broader systems perspective, there are clear implications for rehabilitation intervention. Family therapy is one service which may be appropriate and an article by Dennis Jaffe on "The Role of the Family In Treating Physical Illness" is a real eye opener. Power and Dell Orto provide a helpful outline for assessing families and planning family oriented interventions. The goals they articulate will provide a useful framework for allied health professionals regardless of their degree of involvement with the family. In fact, all service professionals interacting with the family could profit from the training his book offers, while program administrators and planners might consider how well current service systems relate to the families of disabled people.

Over the past decade, our views of disability have been radically altered. The role of the environment and the context in which disability occurs is clearly recognized today as a powerful, if not the powerful force determining the degree of rehabilitation which is accomplished. Yet, while physical accessibility requirements and necessary accommodations are obvious, the psychosocial environment is less easily observed. It is a challenge to understand the "... complicated web of interpersonal relationships" which are the context in which disability occurs. It is also a challenge to re-orient the service delivery system so that the family is effectively supported and used in rehabilitation. This book meets the challenge. Power and Dell Orto have searched and carefully selected from a broad range of social science literature those pieces which can guide us in this new area and endeavor. Without pres-

(Continued on page 21.)

Notes on the margin...

Employers of the year

The Sangamo Weston Components Company of Archbald, Pa., and the Old Bedford Village of Bedford, Pa., received "employers of the year" awards at this year's annual meeting of the President's Committee on Employment of the Handicapped. The Sangamo Company was honored as a large employer (over 200 employees) whose policy for the 20 years of its existence es to give equal opportunity to disabled workers. The Village, among other qualities, was cited for its progressive affirmative action program.

TTY Directory

The International Telephone Directory of the Deaf: 1980-1981 lists TTY numbers of organizations and agencies that serve the deaf as well as people who are members of the organization. The annually updated publication is a 100-page book that costs \$10, with an annual renewal fee of \$5. For further information, contact Telecommunications for the Deaf, Inc., 814 Thayer Avenue, Silver Spring, Maryland 20910. TTY: (301) 589-3006.

Braillegrams

Western Union will deliver large print messages and braillegrams throughout the continental USA. Fees are \$2 for the first 25 words and \$1 for the next 25 words. The toll-free number is 1-800-257-2211.

Disability Information

Mainstream, Inc. introduced a new information service on disability issues. The Mainstream Information Center answers questions of interest to consumers, employers, educators, and rehabilitation professionals. Write to Mainstream Information Center, Mainstream, Inc., 1200 15th Street, N.W., Washington, D.C. 20005. The TTY and voice telephone number is (202) 833-1162.

IRS Rules on Decoders

The Internal Revenue Service has ruled that closed captioned televisions for deaf people can be considered deductible medical expenses under section 213 of the Internal Revenue Code. The hearing impaired people can deduct either the cost of an adaptor that is attached to a conventional TV or the difference in cost between a conventional TV and a television with a built-in adaptor.

Engineers to meet

The annual meeting of the Rehabilitation Engineering Society of North America will be held in the Sheraton Washington Hotel, Washington, D.C. from August 30 through September 3, 1981. Registration fees are \$85 for members, \$95 for nonmembers, \$25 for students, and \$10 for disabled consumers. For further information: Convention Management Consultants, 5401 Kirkman Road, Suite 550, Orlando, Florida 32805. Phone (305) 351-2592.

Optical help

Beamscope lenses are available as attachments to television sets to help low vision people enlarge their TV pictures. The screen is available in three sizes for TV screens from 8 to 12, 13 to 18, and 19 to 25 inches. The smaller screen sells for \$80.95 and the other two are \$125.95 each. Orders or additional information requests may be placed with Ernest Matthews, Beamscope Lens, P.O. Box 8075, Washington, D. C., 20024.

Science for the handicapped

A summer program in marine science for outstanding handicapped students between their 11th and 12th grades will be held July 1 to August 5 at the Marine Science Consortium's Wallops Island station near the Assateague Island National Seashore Park. All types and degrees of severity of physical handicap will be included in the program. The charge for room and board is \$550. with a station fee of \$30. Applications are available from E. C. Keller, Jr., 237 Brooks Hall, West Virginia University, Morgantown, W. Va. 26506. Telephone (304) 293-4380.

Social Trends And Their Implications For Rehabilitation Research

Betty Jo Berland and Richard Leclair

Americans have come to expect change with the passage of time, and for most people during most of the Nation's history, change has meant progress—improvement in their standard of living, life expectancy, economic well-being, education, and physical security. The expansion of knowledge and the furtherance of technology have resulted in widespread benefits. But for some time, social observers have questioned the impact of technology on the emotional, interpersonal, and spiritual well-being of people. Technological advancements have resulted in a reordering of the labor market and posed threats to traditional employment in many occupations. More recently, the scarcity of some natural resources and the limited availability of other resources have dampened the optimism with which Americans have traditionally viewed the future.

Just as historical developments have affected the handicapped population differently from the way they have affected the general population, the consequences of future developments for handicapped people may be different from the expectations for the general population. To assess the implications of projected changes for the long-range planning of rehabilitation research, the National Institute on Handicapped Research (NIHR) convened a 1-day workshop to consider

18 trends in a number of relevant areas.

The workshop attracted participation from a broad spectrum of agencies and organizations concerned with planning for services to handicapped people. Participants included representatives from a number of federal and state agencies concerned with these issues, as well as representatives from private industry, universities, rehabilitation facilities, and consumer organizations. The participants included administrators and planners, researchers in many disciplines, rehabilitation service providers, consumers, employers, and consumer advocates. Although they had little time for advance consideration of workshop issues and little opportunity to contribute to the organization of the workshop, all participants made thoughtful and stimulating contributions.

NIHR plans to conduct additional workshops on the subject of long-range trends and their implications for rehabilitation research and training. The institute intends to expand the advance planning of future workshops, further broaden the base of participation, and provide more opportunity for dialog and review at the workshops.

Within the limited time and resources devoted to the 1980 workshop, many provocative issues with significance for planning were discussed. There was remarkable concurrence on the most important future

trends and their consequences for handicapped people and the rehabilitation field. The workshop included a plenary session and 13 individual panels. Each panel was given only a general format for the discussion. Panelists were asked to determine the assumptions about future developments on which they were predicating their analyses; to predict future trends with respect to handicapped people; and to present the implications of these trends for public policy and the NIHR role.

This paper discusses the major interlocking themes from the workshop and the assumptions and predictions that were presumed to have far-reaching effect on many areas of concern to NIHR.

Common General Assumptions And Their Effects

There are several areas which nearly all of the panels predicted to have important implications for the subjects under consideration: economic trends, health care advances; technological developments; deinstitutionalization; and consumer involvement.

Economic Trend. The economic forecasts predicted limited growth in the economy, with growth in employment lagging behind population growth; lower productivity; and fewer public resources available for rehabilitation and related services.

Health Care Advances. The knowledge and application of health care techniques are expected to advance rapidly. The health care advances will have the effect of reducing the incidence of some disabilities, or certainly of lessening the disabling consequences of some serious illnesses or accidents. The advances in care will also mean the restoration of functional capacity for more people.

Perhaps the major effect of health care advances, however, will be to

increase the disabled population, either by prolonging the lives of those who previously would not have survived, or by increasing the longevity of the general population, with the prevalence of disability increasing with the age of the population.

Technological Development. Advances in technology will affect both rehabilitation prospects and the conditions of life and work for handicapped people. Technology will make possible the restoration of function for many more. Technology will also change the shape of the labor market and the living environment, enabling more handicapped people to function in the system but imposing treatment and training requirements. Panelists stated that technological developments would be most important in altering the nature of work in our society, including the content and the requirements of the work, and the place and time at which it is performed.

Deinstitutionalization. Pressures for deinstitutionalization will continue, based on both humane treatment and direct cost considerations. Continued deinstitutionalization will increase the number of handicapped people requiring services and other accommodations by society.

Consumer Involvement. It is anticipated that consumers and their advocates will continue to be increasingly involved in the planning and direction of rehabilitation services. As a result, pressure for different types of services and demands for better services will increase. The handicapped population will be larger in number, older, and more severely disabled. It will demand better and more comprehensive services and more opportunities to participate equally in the mainstream of American life. It will also want to reap the benefits of anticipated new technology.

This emerging demand will be juxtaposed with constraints on resources and a decline in real dollars allocated to services. Competition for scarce resources will increase and there will be a greater need to establish priorities. At the same time, the handicapped population is expected, like the rest of the population, to encounter more limited economic opportunities; the pool of available labor will exceed any available demand.

Implication For Rehabilitation Research And Services

Perhaps the most encouraging anticipated consequence of these future developments will be an increased emphasis on prevention of impairment. Medical and health care advances, industrial awareness, and advances in the use of public education will combine to stress prevention of impairment and disability. This will be done through such techniques as genetic counseling, early identification and early intervention, improved neonatal care, more successful public education, stronger emphasis on accident prevention, environmental improvements, and better health care as the population ages. This emphasis on prevention will be needed to help offset the expected increase in the number of disabled people in the population.

Service systems will be required to document the value and cost-effectiveness of their rehabilitation services. These systems will also be required to demonstrate the appropriateness and efficiency of their management and service programs. Research units will be required to provide the service systems with closely evaluated service and management models, and to continue to evaluate the efficacy of those systems.

The trend toward private sector

participation in the delivery of rehabilitation services is expected to continue. Competition for the scarce supply of rehabilitation professionals will increase, and there will be demands from both public and private sectors for staff with different kinds of professional training. Staff personnel will require more extensive background in the application of technology in restoration, training, and work-site preparation for handicapped people.

Because of increased demands for timely information about disability by handicapped people and by others working in the system, information providers must be skilled in the use of technology in information storage, retrieval, and communication.

Handicapped people will more actively participate in the planning for research and training, including the determination of research priorities. As a result, there will be increased emphasis on providing the tools for effective advocacy and participation to consumers and their organizations.

Finally, because the handicapped population that uses rehabilitation services will be a more severely disabled one, there will be a great emphasis on independent living services. There are many unanswered questions about independent living, including the most suitable target populations and the most appropriate staffing and structure for the delivery of services. The increased demand for general accountability and documentation of effectiveness will cause problems for the independent living service model, perhaps limiting its ability to be innovative and consumer-directed.

Trend Influence On Development

Demographic Studies. Whereas the total population of the United States is expected to increase 21 percent by the year 2,000, the number of handi- 19

capped people in this country is projected to increase 30 percent during that time. Increased education and the changing nature of work may result in a reduction of disability due to occupational causes. Medical science and technology are expected to reduce the net impact of disability even though they may raise the prevalence of disability through reduced mortality from various causes.

Early intervention and prevention offer the best hope for reducing the prevalence of impairment or its impact.

Employability Training and Placement. There is expected to be an increase in the labor pool but no corresponding increase in demand. Moreover, new technology will affect profoundly the nature of work and employment opportunities. The work force will include more older and more handicapped people. The aging of the work force will lead to a shift in concern to problems of job maintenance for workers who become disabled on the job, rather than to problems of habilitation for entry jobs. The private sector will become more involved in rehabilitation and with the vocational rehabilitation service system.

The concern with job maintenance will generate more attention toward stress-related and age-related disabilities. This will lead in turn to closer relationships between rehabilitation agencies and agencies that serve the elderly population. Because the enlarged disabled population will contain many people with substantial work histories, vocational rehabilitation training will focus more on careers and higher level jobs, rather than on simple job opportunities, often entry-level, as at present.

Technological developments are creating the potential to revolutionize the nature of work. These develop-

ments will have a major impact on the kinds of jobs and working conditions available to all workers, including those who are disabled. Moreover, technology also will increase the capacity of disabled people to overcome handicapping conditions and environmental barriers and will permit them to participate more fully in the mainstream of life.

For example, the electronics industry shows a growing capacity to translate job functions to computerized form, and the cost of sophisticated technology has been dropping sharply. Thus, there is a growing job market in the computer and allied fields. This growth will go beyond computer programming itself and spread to a wide variety of office and other business functions.

Many of these jobs will require a relatively high degree of education and training but will make relatively few physical demands upon job holders; hence, severely physically disabled people will be able to function adequately in these jobs. Increasingly, therefore, colleges will provide more career training for disabled people. For the disabled person to compete in this new sophisticated job market, however, interest in education and an appreciation of early consideration of career options must be fostered. This is especially important for disabled people whose career options are limited. Thus rehabilitation training must begin early.

Another and perhaps more important consequence of this technological revolution is the communication possibilities inherent in these computer systems. Technology allows the person to perform work functions beyond the generally accepted confines of the work environment. Technology and fuel scarcity may create a return to the home as a work site, where working hours will be determined more by the

individual worker than by industrial custom. The rehabilitant trained in the "new technology" can, through terminal hook up, work at home or at a local center for an employer who is miles away. Thus, the homebound person can participate on an equal basis with millions of nondisabled coworkers.

Because transportation barriers will be less significant, the possibility exists that people who live where jobs are scarce can find jobs in more open markets without physically relocating. Thus rehabilitative placement programs can benefit by pooling national labor market and job bank data.

This technology can allow more efficient rehabilitation training, because training for a wide variety of jobs can be carried out through the same equipment and because proximity of client to training facility is no longer necessary. In fact, a person could perform tasks at home, be monitored by a rehabilitation trainer in another locality, and supervised in an on-the-job setting by a supervisor in a third locale.

Futurists are predicting that these changes will affect a large segment of the work force. Obviously these conditions enhance the capabilities of disabled people including the homebound, to compete in the job market. The changes are cost-effective for industry because they reduce space needs in an already overcrowded environment; in addition, reduced travel will help cut demands for energy.

Collection and Dissemination of Information. The "handicapped information" system of the future will be electronically based and operated by information specialists on behalf of a largely handicapped clientele. Hence information specialists must be trained to use the most advanced electronic information systems, and all rehabilitation professionals must re-

ceive basic training in information-seeking methods. Electronic information systems for use by handicapped people must be constantly modified to keep pace with the changes in these systems for the use of the general society.

At present, collection and dissemination of information about disability are inadequate. In the future, more information will be collected through a number of specialized information systems; this information must be repackaged for all target groups and disseminated widely through existing mechanisms.

Most of the many existing information sources are not well known. In the future, people will find it increasingly difficult to identify and obtain access to information sources. A network involving consumer organizations and other communication channels will be needed to help link consumers, especially handicapped consumers, to information sources.

Mental Retardation and Developmental Disabilities. Advances in medical technology and health care could prevent the percentage of developmentally disabled people in society from increasing by counterbalancing higher survival rates with better prevention practices. The most important research development would be a major increase in the emphasis on the prevention of mental retardation.

It is expected that during the next decade a good system of early identification and treatment for people with developmental disabilities will be developed. At the same time, parents of developmentally disabled people will expect and demand comprehensive services at the earliest possible age for their off spring. As a result, additional trained staff personnel and an expanded delivery system will be needed to meet higher expectations.

Mentally retarded people will continue to require services that will be provided through a number of different delivery systems. Case management systems will evolve as the preferred mechanism to expedite services and assure their quality. Research agencies will be expected to develop, test, and disseminate effective case management models.

Deinstitutionalization will continue, and the Federal Government will offer financial incentives to encourage states and localities to return more developmentally disabled people to the community. As a result, demand will grow for expanded community support systems for disabled people and for their families, who will care for developmentally disabled children at home.

Many electronic devices—including individual, computerized learning programs, with instant electronic feedback and reinforcement—can help the mentally retarded to learn and develop in the community setting.

Management of Services. In the next decade, the scope of rehabilitation services is expected to broaden beyond the vocational emphasis to encompass all areas of life. Major research efforts will be needed to design and manage total rehabilitation programs, individually targeted but working toward a range of rehabilitation outcomes.

Many sources will be pressing for more effective rehabilitation services and for demonstration of effectiveness. Research must develop and justify management systems and provide methods by which service providers can achieve greater accountability and meet federal standards without sacrificing the amount or quality of staff effort and other resources devoted to client services.

In sum, the rehabilitation field is

dynamic; the coming decades will see more changes in the content and administration of rehabilitation services than can be anticipated now. Rehabilitation research must provide the means to adopt advances in technology, medical care, and public and consumer awareness to serve the needs of the handicapped population. Research also will be expected to help design a service system that will reconcile the demands of consumers with the constraints of the economy, and satisfy the standards of funding sources in the competition for scarce resources.

Ms. Berland and Mr. Leclair are staff members in the National Institute of Handicapped Research.

REVIEW

(Continued from page 15.)

enting "a model" of family functioning, they have provided a framework for integrating this exciting new work and using it to plan new intervention strategies.

The fact that we are all family members makes this new area of analysis a fascinating one for rehabilitationists to consider. We can all reflect on the unique forces in our own families and how the introduction of disability might reverberate throughout our own family system. The book is a call to consider this kind of question. Our willingness to consider it is probably a good indicator of how well we relate with families. *The Role of the Family in the Rehabilitation of the Physically Disabled* causes us to consider such questions, and in this respect it succeeds greatly.

Chris Wood, CRC, is a Graduate Student Intern, Clearinghouse on the Handicapped.

By Ned Burman

IYDP News And Notes From Here and There

The International Year of Disabled Persons is generating world-wide support according to the United Nations Secretariat. Interest has been stimulated at home and abroad as IYDP activities gain coverage in news media. This column will carry news of significance to handicapped people during the international year.

IYDP—1981 received two major endorsements in February, a proclamation signed by President Ronald Reagan and a Joint Resolution passed by the Senate and House. The presidential proclamation said, "Through partnerships of disabled and nondisabled persons; of our private sector and our government; and of our national, state and community organizations, we can expand the opportunities for disabled Americans to make a fuller contribution to our national life."

Round-the-World Athletes for IYDP were honored by the Federal Secretariat for the international year at a reception at the Department of State in Washington, D.C. The Athletes, all with disabilities, representing 10 countries, arrived in Washington after a world tour of competition in winter sports events. Their tour concluded in Vinland, Minnesota.

Harold O'Flaherty, Executive Director, of the Federal Secretariat, International Year of Disabled Persons, told the American Occupational Therapy Association at a convention in Houston, Texas, about IYDP plans for 1981. O'Flaherty said, "it is important to train both the providers of health care and the disabled people themselves how handicapped individuals can actively participate in their own lives and in society."

The North Coast Regional Center in Ukiah, California, representing a four-country area organized a community workshop to plan a task force in support of the international year. A Call-to-Action program was launched to focus on the IYDP theme of full participation of disabled people in community life. Special committees for IYDP planning were established in Mendocino, Lake, Del Norte, and Humboldt counties.

Dr. Gunnar Dybwad writing in *NEWS*, published by the International League of Societies for the Mentally Handicapped, commented about the "consumers" movement for retarded people: "There is a new voice in the world of mental retardation, a little unsure but steadily gaining strength. It is the voice of mentally retarded people themselves—those once considered uneducable, who now attend schools; those once determined unemployable, who now bring home paychecks.

"I am gratified to know that mentally retarded people participate in deliberations that affect them. They have begun to manage discussions, learn how to vote, conduct meetings, and abide by group decisions. They have begun to make critical reactions to the well-meaning programs designed for them."

A multi-media campaign on employability of people with disabilities is currently running on television, radio, and in newspapers nationwide. Public service announcements were sent to 779 TV stations, 3,700 radio stations and to 1,737 newspapers, and 248 special publications. The series was produced by Portfolio Associates of Philadelphia, under contract to Rehabilitation Services

Administrations. In keeping with the theme of IYDP, the spots stress the abilities of handicapped people.

A Special Child—James Elmore of Grand Island, New York, has written this poem, "A Special Child," as a tribute to the 1981 International Year of Disabled Persons:

Special children
With special needs
Raised in the world
For all to see
Trying to become
What they can
To live in this world
With their fellow man
Being taught
What they need
To cope with life
and reality
Potentials and goals
They'll try to seek
Their highest hope
Their normalcy

Deaf People "Listen" To Radio

Mrs. Mary Pat Boyle, a rehabilitation counselor in the Philadelphia district office was the featured guest on a pioneering radio-for-the-deaf live talk show on October 16th. Mrs. Boyle responded to questions "called" in through telecommunication devices which also decoded her replies for "listeners."

Operated by the Pennsylvania School for the Deaf RTTY/TTY News Center in cooperation with Temple University's station WRTI-FM, the program presents news of interest to the Philadelphia area deaf community.

—*BVR Success*, Pennsylvania Bureau of Vocational Rehabilitation.

Which Way Is Program Headed? Mixed Signals In FY 1980

Larry Mars

Caseload volumes and flows in fiscal year 1980 exhibited quite a varied pattern compared to the recent past. Much of what occurred represented a continuation of the contraction in the number of cases that has characterized the state-federal program in the last few years. Some observed activity, however, constituted a distinct break with the past, particularly where numbers of severely disabled people were concerned.

Continuation Of Recent Trends

In many ways, caseload volumes in fiscal year 1980 followed patterns established in recent years. The number of persons vocationally rehabilitated, for example, declined from the prior year by 3.9 percent to 277,136, the lowest total in 10 years, and the fifth annual loss in the last 6 years. The number of people who received rehabilitation services fell by 2.9 percent from fiscal year 1979 to 1,095,139, the fifth consecutive annual loss. Another recent phenomenon, the decline in the number of people in active receipt of rehabilitation services on the last day of the fiscal year, also continued. This time such people numbered 665,331 on September 30, 1980, a decrease of 2.6 percent from the same date a year earlier, and the fifth consecutive end-of-year decline.

Overall, the total number of people known to state rehabilitation agencies at some time during fiscal year 1980, including those on whom a minimal amount of information had been gath-

ered, dipped by 1.7 percent from the year before to 1,988,205, the fifth straight annual decrease, and the first time in 9 years that this measure fell below 2 million.

Even for some aspects of caseloads of severely disabled people there was a "deja vu" look. The proportion of the severely disabled, for example, among people rehabilitated increased for the sixth consecutive year, this time to 51.4 percent, topping the 50 percent level for the first time. In addition, the severely disabled accounted for 55.3 percent of all people actively served in fiscal year 1980 and 56.0 percent of all such people whose cases were still in process on September 30, 1980, continuing the trend of increasingly higher percentages for these measures in the 5 years during which these statistics have been obtained.

Departure From Recent Trends

Despite the "sameness" of so many of the caseload trends in fiscal year 1980, clear breaks with the recent past were established. This was initially apparent with increasing numbers of new cases entering each of the major stages of the vocational rehabilitation process for the first time in 5 years. People newly referred to state agencies rose by 2.7 percent from fiscal year 1979 to a level of 912,294; people newly applying for services increased by 3.6 percent to 722,847; and people newly accepted for rehabilitation services

edged forward by 0.2 percent to 412,356.

Two very surprising changes from recent caseload trends occurred with first-ever annual declines recorded in the number of severely disabled people served and rehabilitated. Those served declined by 1.0 percent from fiscal year 1979 to 606,049 and those rehabilitated by 0.6 percent to 142,545. Despite these decreases, the number of nonseverely disabled people served and rehabilitated declined to an even greater extent, leading to increasing percentages of the severely disabled among all people served and rehabilitated in fiscal year 1980.

Yet, the most stunning reversal of recent caseload form occurred relative to the number of people newly accepted for vocational rehabilitation services in fiscal year 1980. For the first time in 3 years new severely disabled cases showed an annual decline, this one by 0.7 percent, to 224,729 cases, while the number of new nonseverely disabled cases increased by 1.3 percent to 187,627, the first such annual increase since the statistical series on the severity status of people in the active caseload was established in fiscal year 1976. These trends meant that the caseloads of new active cases in fiscal year 1980 were composed of relatively fewer severely disabled people (54.5 percent severe) than in fiscal year 1979 (55.0 percent severe).

Concluding Observations

It is too early to ascertain whether or not the previously-mentioned reversal of caseload trends observed for fiscal year 1980 represent something new, or merely single-year deviations. It is interesting to note, however, that state agencies were somehow able to increase their intake of new cases for

(Continued on page 32.)

ABLEDATA is an information bank for rehabilitation products. The computerized data retrieval system is designed to provide information on commercially available aids and equipment used by disabled people. Product data entries include descriptions, procurement information, and consumer use comments and information. Formal evaluation data will be included as it is available.

The need for a national information bank for rehabilitation products has been identified by many groups with interests in the field of rehabilitation: disabled individuals, health professionals, state rehabilitation agencies, and other related services and agencies, researchers, developers, educators, and manufacturers. ABLEDATA is a pilot project, supported by NIHR, designed to meet this need. Fifteen centers, the National Rehabilitation Information Center, and other programs supported by the NIHR are working together to compile the data and develop the system. These include rehabilitation engineering centers and programs, the California State Department of Rehabilitation, and the National Rehabilitation Information Center.

The product data base is considered the first phase of ABLEDATA. With success of this pilot project, other phases are planned; including a custom design or one-off design data base, incorporating listings of services, agencies, and organizations, and an international sharing capability.

During the pilot project and evaluation, ABLEDATA is accessible to anyone desiring information through information brokers only. For the pilot project, information brokers are

needed to assist in developing the network and for control in gathering statistics and feedback on use of the system. The need for use of the information brokers as an interface to ABLEDATA will also be evaluated.

Responsibilities of the information broker include providing assistance to users, including interpreting requests and questions appropriately, and interpreting resulting data from the files. All resources listed in the ABLEDATA files are either manufacturers, sole distributors or national distribution with unique catalogs. It is also the broker's responsibility to develop files for their local and regional vendors, resources and services to complement the national files. For the pilot project, microcomputers will be used by the brokers to develop the local files at each of the identified sites, but these files can also be maintained by a manual filing system.

It is anticipated that a teleconferencing capability will eventually be included with the system. This will inter-link individual brokers with an "electronic mail" system, allowing brokers to "talk" (*i.e.*, exchange ideas, discuss difficult or very special requests) with one broker, or include in a conference message as many brokers as desired. Through teleconferencing centers or brokers with expertise can be used directly, in addition to ABLEDATA files, to respond to special requests.

It will also be the responsibility of the brokers to document use of the system. A history of transactions will be maintained to document all information requests and responses for evaluation of the system. This data will also be used to assist in determining future charges for the system.

Experience of the pilot project in-

formation brokers will also be used to develop training programs for future brokers or direct users. The training program is to be developed in the coming year. Also, a thesaurus is in development to assist in accessing the ABLEDATA files.

The data files currently on line are considered a test data base. They consist of nearly 1,000 items within the Personal Care and Home Management categories. By Spring 1981, ABLEDATA will be expanded with approximately 3,000 entries including new and updated entries in these two categories and 10 new categories of equipment.

For information on ABLEDATA: Marian G. Hall, National Director—ABLEDATA, P.O. Box 3368, University Station, Charlottesville, Va. 22903. (804) 977-1378; The National Rehabilitation Information Center, The Catholic University of America, 4407 Seventh Street, N.E., Washington, D.C. 20064, (202) 635-5822 (voice) (202) 635-5884 (TTY).

For product information: Carol Clerico, OTR, University of Virginia, P.O. Box 3368, University Station, Charlottesville, Va. 22903, (804) 977-1378; Paige Finnerty, Rancho Los Amigos, 7601 East Imperial Highway, Downey, Calif. 90242. (213) 922-8116; Rosemary Murphy, Children's Hospital at Stanford, 520 Willow Road, Palo Alto, Calif. 94304. (415) 327-4800; Jim Christenson, State of California, Department of Rehabilitation, 830 K Street Mall, Sacramento, Calif. 95814. (916) 323-2959.

Early Childhood

For years the mandate of the vocational rehabilitation program has been to deal with a working-age population with vocational potential. In pursuing this primary mission, the system

often could not serve or study younger people. The 1978 Amendments obligates NIHR to direct some research and demonstration activity toward handicapped younger children. A priority for FY 1980 funding was developing innovative methods of providing services to severely handicapped children to age 3 and those who are at high risk. Four projects responsive to this priority are described below:

University of Illinois/Chicago Circle: Early Intervention with At-Risk and Handicapped Infants in Multi Hospital, Multi Program Areas.

Early intervention with handicapped and at-risk children has been demonstrated as facilitating the child's later development and reducing the need for public care. However, in most metropolitan settings, there are delays both in diagnosis and between the time diagnosis is made and actual placement in an appropriate program.

This project is to reduce the time between birth and enrollment in an early intervention program; to support parents during the initial, stressful adjustment to having a handicapped child; to provide the child with a complete evaluation, to train parents to give care and foster the development of their child; and to provide parents with an entry into the service system for the continued care and education of their child.

Connections will be made with the newborn units in major local hospitals for referral in the Early Infancy Intervention Program. The child and family will be served in the program during the first year of life. The family will then be referred to community programs for continuing early intervention until the child reaches age three.

Project results will be disseminated as an innovative model of early intervention with at-risk or handicapped

infants. The model will be considered for implementation on a state-wide basis by governmental agencies.

University of Oregon: The Development of Evaluation of Strategies for Monitoring, Assessing and Intervening with Groups of At-Risk Handicapped Infants, Preschool.

During this past decade, there has been a dramatic increase in this Nation's concern for handicapped individuals. This concern is reflected in efforts to reduce barriers for physically disabled citizens, in the provision of a more normalized environment for handicapped children through mainstreaming, in the elimination of tests or procedures with clear cultural and class biases; and in the inclusion of more severely impaired people in schools and local community activities. While progress has been significant, great challenges lie ahead. In reviewing the progress of the 1970s, it is apparent that the significant allocation of federal and state money for demonstration, research, and service efforts has been of major importance.

Now, with increasing fiscal constraints, we are faced with diminishing budgets even as service costs rise; there is pressure to serve more people more effectively. In view of these circumstances, it seems appropriate to begin with a careful examination of current practices in the light of using limited resources in a more cost-effective manner. In particular, the thrust of this project is to explore the systematic inclusion of parents in roles currently filled almost exclusively by highly trained professionals.

Three interrelated components address this goal. One explores the use of parents as monitors of their own at-risk infant's development. The second collects information on a number of comparisons between traditional and nontraditional measures and be-

tween parent and professionally administered tests. The third determines the effectiveness of parents as interveners with other parents. The goal is significant both in terms of enhancing the quality of services being delivered to at-risk and handicapped infants and of deploying limited resources for the delivery of such services in most cost-effective ways.

Loyola University of Chicago: The Neurodevelopmental Outcome of High Risk Infants.

The goal here is to document the neurodevelopmental outcomes of infants who are at highest-risk for handicapping conditions (less than 1,501 grams with intracranial hemorrhages) in a double-blind prospective study. The degree of hemorrhage will be objectively documented by computer tomography (CT brain scan) and outcome will be related to standardized and innovative functional assessments (Criterion-referenced with inter-rater reliability) at birth and at intervals up to 36 months. A comparison group will be selected of infants less than 1501 grams with no evidence of hemorrhage by CT brain scan.

The project is located in a perinatal high-risk center to which high-risk infants are referred from 13 hospitals who annually deliver 20,000 infants.

West Virginia University, University Affiliated Center, College of Human Resources and Education: Intervention Program for High Risk and Handicapping Conditions in Children up to age 3.

The primary goal here is to develop intervention strategies that deal with the problems of severely and multiply handicapped, high risk children. Objectives emphasize an interdisciplinary approach of prevention, early identification and treatment (with

(Continued on page 32.)

Special Education-Vocational Rehabilitation Let's Get The Act Together

Joseph Fenton, Ed.D., and Robert A. Keller, Jr.

Just as "love and marriage go-together like the horse and carriage" so should special education and vocational rehabilitation. Although the two agencies have been courting each other intermittently for several decades and more or less "living" together in various sections of the country, a real and a lasting "marriage" of the two has never been totally consummated.

All too often, both special education and vocational rehabilitation have had a "tunnel vision" approach to their own areas of responsibility and how they looked at each other. Their respective goals and objectives have frequently been narrowly and independently circumscribed to limited needs of handicapped persons at specific ages. The focus has been on specific, unsequential programmatic details with little or no recognition that the common concern and mission is for the same handicapped person.

Surely, both special education and vocational rehabilitation are "in business" to assist people with handicapping conditions to develop their physical, emotional, educational, social, and vocational potentialities to the fullest. Special education has the greater, but not exclusive, responsibility to assist in reaching the common goal during the earlier years of the handicapped person's life; vocational rehabilitation at a later period. Each agency has its own unique skills, assets, and attributes that can be helpful to the other. Together they possess the sum total of ingredients necessary to assist handicapped people

to achieve a maximum level of productivity and function.

A review of the history of the relationships between special education and vocational rehabilitation reveals that the delivery of collaborative services is not a new concept. Cooperative programs were evident in a variety of ways. Among them was the "work study" programs, prevalent in the late 1950s and early 1960s. Handicapped students in high school (usually in special classes for mentally retarded children) attended school for a half day to receive academic instruction along with daily-living and job related skills. The other half day was devoted to "on-the-job" training and experiences, usually under the supervision or in collaboration with a vocational rehabilitation agency counselor. Under other circumstances, vocational rehabilitation counselors worked in school facilities on a part-time basis, assisting handicapped students and the teacher in planning for vocational goals.

In 1958, Fenton and Goldberg reported* that the Rochester, New York, Public School System established a full-time "coordinating-teacher" position (whose salary was reimbursed by the State Education Department) to work with physically handicapped secondary school stu-

dents who received special transportation to a central high school and mainstreamed in "regular classes." The skills of this fully certified and experienced special education teacher were enhanced by a grant to attend a compacted, 6-week summer course in rehabilitation counseling, thus becoming knowledgeable in both special education and vocational rehabilitation. The students were helped in their transition to the regular high school by virtue of the interviews conducted by the coordinating teacher while they were in the last year of their elementary school "special" classes. Once in high school, occupational information materials were made available to provide an awareness of the demands of various vocations. The students were taught personal hygiene, good work habits, and grooming in order to prevent a social handicap. They were also helped to develop realistic vocational goals and in the selection of appropriate courses of study. However, one of the most important responsibilities of the coordinating teacher was to establish an early relationship between the student, the vocational rehabilitation agency, and the school. The teacher maintained and coordinated these efforts within the total school experience.

More recently, there have been a number of highly significant events that served to focus attention on vocational objectives for special education students. One such event in the early 1970s was the introduction of career education into programs for handi-

* Fenton, J. and Goldberg, H., "Rochester Aids Handicapped Children." *Bulletin to the Schools*, University of the State of New York, State Education Department, Albany, New York, May 1958.

capped students. This was a response by the U.S. Office of Education, Bureau of Education for the Handicapped, to a concern expressed by the U.S. Commissioner of Education, that the needs of students were not being met by the educational system. It resulted in efforts to introduce into the primary school curriculum information and knowledge about the world of work. As the student progressed in age and grade, more concrete experiences were provided which helped the student make appropriate career choices.

In November 1978, the Commissioners of Education and Rehabilitation issued a joint memorandum establishing a task force to develop guidelines for collaborative planning and service delivery. This was followed, in February 1979, by a National Special Education-Vocational Education-Vocational Rehabilitation Workshop on Cooperative Planning for the Handicapped. The impact of the memorandum and the workshop stimulated and encouraged the state agencies to follow the federal lead.

Interest in coordinating the delivery of services to the handicapped was further stimulated by the language and intent embodied in the legislation which affected those programs. The Rehabilitation Act of 1973 (PL 93-112), the 1974 Amendments to PL 93-112, the Education for All Handicapped Children Act (PL 94-142), the Vocational Education Amendments of 1976, and the CETA Amendments of 1978 (PL 95-424) are replete with references which encourage and require coordination of service delivery to handicapped people. The most heartening piece of legislation was, however, the enactment of the Department of Education Organization Act (PL 96-88-Oct. 17, 1979), establishing (Sec. 207) an Office of Special Education and

Rehabilitative Services Administered by an Assistant Secretary.

In spite of progress made, the goal of providing planned, timely, and efficient services to handicapped citizens has not yet been achieved universally. With the awareness of the needs of the handicapped population and the legislation which has been enacted in their behalf, there are obstacles that still impede total achievement of the goal.

Several of the unresolved problems are: lack of common terminology and definitions; long delays in the delivery of services; gaps in service delivery as client eligibility shifts from one program to another; duplication of effort by the helping agencies; confusion and delay caused by varying organizational structures and operational procedures; increased demand for services; and shortage of personnel and material resources due to inflation, rising costs, and increased competition for funds.

Nevertheless, there are reasons to be optimistic. Programs are being implemented by education and vocational rehabilitation agencies in several states which are having a positive impact on reducing many of the perennial obstacles to effective service delivery. One of the most promising alternatives that states have undertaken is the formalization of coordinating efforts by establishing interagency cooperative agreements. These agreements outline the manner in which the services rendered will be planned, coordinated, and delivered by the special education, vocational education, and vocational rehabilitation agencies. The formalized ties provided for consistent rather than sporadic collaboration and brought vocational education into the process as a third partner.

Interagency cooperative agreements are gaining popularity among

agency administrators and practitioners. Much of this interest can be attributed to the initiatives taken at the federal level.

Administrators and practitioners are also attracted to the cooperative agreements because of the potential they see in the process for addressing the comprehensive needs of handicapped people. Properly implemented, the potential of coordinating service delivery is enhanced and can result in the reduction of delays and gaps in service delivery, duplication of effort, and confusion caused by terminology differences, organizational structure, or operating procedures. Importantly, with the application of proper managerial skills, the participating agencies can make better use of their limited resources.

Many states followed the federal initiative and have developed interagency accords. Others, such as Michigan, California, New York, Texas, and West Virginia have advanced further by promoting interagency agreements at the local level, and, through their experiences, a pool of information is being developed concerning the process of successfully initiating and implementing state and local level interagency pacts.

Some of the lessons learned from the field may be helpful to those planning to implement local level agreements. As an example, a vigorous display of enthusiasm, interest, and acceptance on the part of the state superintendent of schools and the state director of vocational rehabilitation resulting from the need to coordinate the efforts of their respective agencies is essential to the success of the process. This should be followed by a signed document outlining the details and the specifics of the commitment of each agency. This document usually becomes the prototype for the agreements to be de-

veloped on the local level when counterparts of the education department special education and vocational education staff meet with the vocational rehabilitation agency representatives to jointly develop a statewide implementation plan. This includes strategies to bring about assurance that the state plans are implemented.

One of the three agencies should assume the responsibility for implementing the process. Unless this is done, the agreement may simply become a paper transaction. A number of the vocational rehabilitation agencies have seen this leadership role as proper for them to assume because of their concern for handicapped people over a longer span.

Experience has demonstrated that the most important ingredient necessary for the success of the cooperative effort is the degree of commitment which the parties are willing to give to the project. While the signed agreement is a symbol of that commitment, by itself, it is only a piece of paper.

Another necessary guarantor of success is the availability of a support system for the rehabilitation and education personnel who will be responsible for implementing the terms of the agreement. This kind of mechanism must provide technical assistance to help the participants acquire the knowledge, skills, and techniques essential for coordination, communication, and cooperation.

In West Virginia, the Research and Training Center of the National Institute of Handicapped Research is aiding the School Services Section of the West Virginia Division of Vocational Rehabilitation in providing staff development and technical assistance to the local school system and vocational rehabilitation cooperating agencies. In so doing, the RTC anticipates developing a model which will be field

tested and published for availability to all who are interested in cooperative agreements.

On the basis of the West Virginia experience and that of others, it should be noted that there may be some reluctance or suspicion of vocational rehabilitation agencies' motives. Education's hesitation is somewhat understandable in view of their broad charge. Also, while the funding to meet the increased mandated school services for handicapped and minority populations has not been adequate, advocacy groups have targeted their frustration and criticism at the schools because the school is visible and accessible. As a consequence, it is essential that the vocational rehabilitation agency appreciate the vulnerability which schools have and initiate an approach to the schools which is positive and supportive.

The school systems are looking for help, particularly from vocational rehabilitation, because they have not developed competencies in the areas of vocational assessment and placement even though they are required to provide these to handicapped students as "related services." However, their initial reactions, when approached, may be based on the misassumption that vocational rehabilitation is going to add to rather than share their burden. Vocational rehabilitation is generally not viewed as an ally and support until after an opportunity has been given to demonstrate the ways in which vocational rehabilitation can help and what the advantages are to the student and the education agency.

The commitment, attitudes, and competencies of those who are charged with implementing agreements are vitally important. Rehabilitation counselors, special education teachers, vocational education teachers, guidance counselors, and building principals are all involved in the

implementation process. Education and professional experiences of rehabilitation and education personnel have generally been isolated from each other. If the agreements are to be meaningful and result in effective and efficient service delivery, emphasis, effort, and resources must be devoted to inservice and staff development activities. States which have experienced success have recognized and attended to this need. Additionally, in formulating an implementation effort there should be an awareness of the following:

1. Special and vocational educators have only a minimal familiarity with the programs of vocational rehabilitation.

2. Special and vocational teachers are not generally aware of the mission of vocational rehabilitation and the ways in which its mission complements their own.

3. Teachers who work with handicapped students do not generally have the opportunity to interface with the vocational rehabilitation counselor. Contact with the schools by vocational rehabilitation is generally with and through the guidance counselor.

4. There is some fear that vocational rehabilitation will interfere or interrupt school programs.

5. There is a need for special educators and vocational rehabilitation counselors to identify the many ways in which their goals for helping students dovetail and how cooperative efforts can improve service to eligible students.

6. All of the professionals who work with handicapped students need to view the person in totality and design planned and coordinated programs that meet the student's needs through all stages of development.

7. Both special educators and vocational rehabilitation personnel need to understand that the ultimate goal of

vocational education and the measure of its success have been placement of its graduates. This may not be appropriate for meeting needs of special students.

Similarly, there are information gaps and special needs that rehabilitation personnel have as participants in cooperative efforts. These areas need to be addressed with the same vigor as those which pertain to the educators. They are:

1. Vocational rehabilitation personnel are generally as uninformed about schools as the school people are about them.

2. Vocational rehabilitation counselors have not always been welcome in the schools. Confusion, misinformation, etc., have to be replaced with mutual understanding and appreciation.

3. Rehabilitation personnel need to become familiar with the organizational characteristics of the schools and particularly the ways in which access can be gained or prevented.

4. Meeting the needs of the handicapped students is only one of several significant goals for which school personnel are held accountable. Lack of funds, trained personnel, and public criticism for the failure to properly respond, cause educators to be particularly sensitive to being "pushed" further.

5. Vocational rehabilitation counselors must get to know, meet with, and support special educators.

6. With the agreement becoming a reality, the vocational rehabilitation counselor's work load will increase. Thus, the counselor must have the assurance of support and backing of the vocational rehabilitation agency.

7. Special training for vocational rehabilitation counselors working in the schools, particularly in large metropolitan areas, is helpful.

8. It is as important for the voca-

tional rehabilitation counselors to know the vocational educators in his/her district as it is with special educators and guidance counselors.

9. Special sensitivity, group processes, and facilitation skills are important to vocational rehabilitation counselors who become involved in implementing cooperative agreements.

In addition, the vocational rehabilitation counselor needs to be aware of the internal dynamics within the schools that affect the attitudes and openness of the education colleagues.

Being sensitive to the following will help vocational rehabilitation counselors be a more effective partner in the agreement: that some special education personnel feel that they are shouldering too much responsibility for the handicapped students and that there is little time to devote to meeting or planning sessions which do not directly affect students; that the role of the special education teacher is being changed to that of a consultant. As a result, time is needed to adjust to and internalize this new expectation; that in the past, special educators and vocational educators have had difficulty in agreeing on the needs of handicapped students. (Continued dialogue is necessary in order to enlist both as partners in implementing the agreement.); that special educators are sensitive to negative reactions to PL 94-142 held by some teachers and administrators, *i.e.*, "They are dumping their problems on the regular teachers;" and that vocational educators are very conscious of the safety hazards which exist in their shops and because of inexperience in working with handicapped students may be overly concerned about their safety.

There are also a number of areas in which the vocational rehabilitation counselor can be helpful to both the

school and the handicapped student preliminary to his or her eligibility as a client of the vocational rehabilitation agency. These include: Clarifying eligibility requirements to provide assurance that all students who are eligible for vocational rehabilitation services are identified; participating in the development of the student's Individual Educational Plan so that the program designed for the student will be maximally coordinated and continuous; participating on the school's Interdisciplinary Committee in order to provide an additional perspective for alternatives that extend beyond those normally considered; and beginning at the elementary school level to provide information and insights to teachers, parents, and students about handicapping conditions and vocational information.

With all of these precautions, there are some resolvable questions that may still need clarification in order to reduce operational difficulties. State and local action can reduce or eliminate some but others may require federal action or special studies. They include:

1. Local interpretations of regulations, *i.e.*, can evaluations done by school psychologists be used by rehabilitation personnel?

2. Are considerations being given by the state or local agency to assist vocational rehabilitation counselors with increased client loads?

3. What changes are needed in the training of rehabilitation and education personnel to prepare them for collaborative programming?

4. What criteria are needed to evaluate the effects of cooperative agreements?

In summary, the unification of the mission, goals, and objectives of special education, vocational education, and vocational rehabilitation is a concept whose time is long overdue.

The extent to which the disabled child with a disability today becomes a handicapped adult of tomorrow can be substantially reduced through early and ongoing collaborative planning and programing. And, the transitional phases from childhood to productive adulthood can be accomplished with the maximum amount of ease if collaboration becomes an active, standard operating reality.

For sure, the era of coordination of services is with us. The promise it holds for eliminating the long delays, for providing continuous assistance, for coordinating the efforts of all agencies involved in helping special students, for avoiding duplication of effort, and enabling agencies to make more effective and efficient use of their resources is intriguing. The possibility that this alternative can increase the chances that needed, effective, appropriate, and timely assistance will reach each eligible handicapped person must be continuously explored. More vocational rehabilitation agencies must assume leadership roles in developing and implementing interagency agreements at the state and local levels in order to capitalize on the potential which cooperative agreements hold; to enrich their present programs; and, to gain new understandings and insights. Most importantly, it is the handicapped person who will benefit from an early and ongoing, collaborative special education-vocational rehabilitation service program.

Dr. Fenton is Director of Research and Training Centers program of the National Institute of Handicapped Research. He served as Special Consultant in the Office of the Assistant Secretary for Special Education and Rehabilitative Services and has an extensive background in the process of interagency coordination.

Mr. Keller is the Administrator, West Virginia Research and Training Center in Vocational Rehabilitation. He is a former Secondary School Principal and is an Adjunct Professor at the West Virginia College of Graduate Studies.

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Review: Handicapped Child In School

Edna Adler

The fast approaching influx into vocational rehabilitation of thousands of young handicapped adults, the victims of the congenital rubella epidemic of 1963–1964, has created an urgent need in vocational rehabilitation personnel for information on this special population. A new book, *The Handicapped Child in School: Behavior and Management*, by Stella Chess, M.D., and Paulina Fernandez, Ph.D., of the Department of Psychiatry, New York University Medical Center, appears to be an information resource that staff at vocational rehabilitation agencies and facilities should find quite useful. Developed for teachers, parents, and others who deal with handicapped children, especially the multi-handicapped, the book provides a longitudinal view on their development that is unique in the literature on this special group. It is brought out that while much longitudinal data is available on normal children, few studies to produce such data on handicapped children have been made.

Dr. Chess and Ms. Fernandez base much of the discussion in their book on data they gathered in a longitudinal behavioral study of 243 children who were born with congenital rubella. Begun when the children were in the 3.5 year age range and continuing through their 13th–14th years, the study produced psychological data that had not until then been available. It may be hoped that longitudinal study of handicapped people born

with congenital rubella may continue and cover the critical late adolescent years and the twenties. In the meantime, the Chess-Fernandez study is a valuable source of information as well illustrated in the book that the pair published early this year.

The enactment in 1975 of Public Law 94–142 vastly increased the number of handicapped children attending regular classes in public schools. Unfortunately, little information was available to teachers on the development and the management of such children. Additionally, few mental health consultants then and even now are in a position to provide assistance to teachers with the frequently unusual behavior of handicapped children. It is of note that the book, *The Handicapped Child in School*, was developed principally for the public school teacher whose problems are quite different from those who work at special day programs or residential schools. This can be fully appreciated when one considers that mainstreamed handicapped children in a single classroom may represent various types and degrees of handicaps with some of them being multi-handicapped.

The authors have worked extensively with teachers of handicapped children, putting together data on observed problem behavior. The identity of particular behaviors that present problems to teachers with suggestions for their management comprise the core of the book. Care is taken in

pointing out that behavior in handicapped children is more fixed and permanent than in nonhandicapped children. The longitudinal study that the authors undertook on a group of children born with congenital rubella indicated, for instance, that multi-handicapped children are more likely to carry early behavior patterns into adolescence than children with a single handicap. Exposure of vocational rehabilitation counselors to early adolescent handicapped individuals takes on new importance in light of the wealth of data that the research conducted by Dr. Chess and Ms. Fernandez provides. That education and vocational rehabilitation must work more closely than ever to assure best possible rehabilitation outcome for the many congenital rubella handicapped youth now nearing rehabilitation age is beyond a doubt.

Presented in three parts: Development in Perspective, The Handicapped Child in Society, and Behavior and Management, the book goes from the general to the specific, with the ultimate objective being the orientation of teachers to the development of handicapped children. Six disabilities, deafness, blindness, deaf-blindness, motoric, brain injury, and mental retardation and behavior are addressed with the behavioral symptoms most common to each disability being defined with advice on management offered in each case. The role of parents and community resources in the development of handicapped chil-

dren as coworkers with teachers is described. More effective relationships among education, the home, and the community to benefit handicapped children are seen as a pressing need.

The authors regard as their most important objective providing teachers with a long-range perspective on development in handicapped children. They point to the dearth of normative data on handicapped children in contrast to the guidelines and signposts available on development in non-handicapped children. To help teachers in acquiring a better understanding of the longitudinal development of the physically handicapped child, the authors have covered issues relating to developmental and behavioral expectations, the influence of socioeconomic, environmental influence affecting the child's development and behavior, differentiating behavior consequential to a handicap from that having no relation to it, aids for dealing with problem behavior, involving parents and others in assisting the child, and using the services of available mental health personnel.

Repeatedly, the authors refer to the adaptability of handicapped children and their capacity to rise above their difficulties, to cope, and to measure up to many of the expectations held for normal children. Early encouragement of appropriate behavior in handicapped children as is done with normal children may be viewed as a first step in their rehabilitation. Adolescent handicapped students were found to have a particularly trying time in mainstreamed programs. Only a step away from vocational rehabilitation, they clearly merit the early attention of vocational rehabilitation counselors who will soon be working with them.

32 Interestingly, there is no mention in the book of teacher aides such as

interpreters for deaf and deaf-blind children, readers for blind children, and special assistants for the motoric disabled, brain injured, and those who are mentally retarded. Their presence as needed may be implied. Certainly it is difficult to visualize a single teacher coping with a classload that in addition to normal children may include a variety of handicapped children requiring differing behavior management and teaching techniques.

Teachers, parents, and community services programs responsible for the development of handicapped children have acquired a valuable resource in the book, *The Handicapped Child in School: Behavior and Management*. Vocational rehabilitation which will soon be assuming the responsibility for the rehabilitation outcome of many of the 1963-64 congenital rubella handicapped children has also been provided a much needed reference.

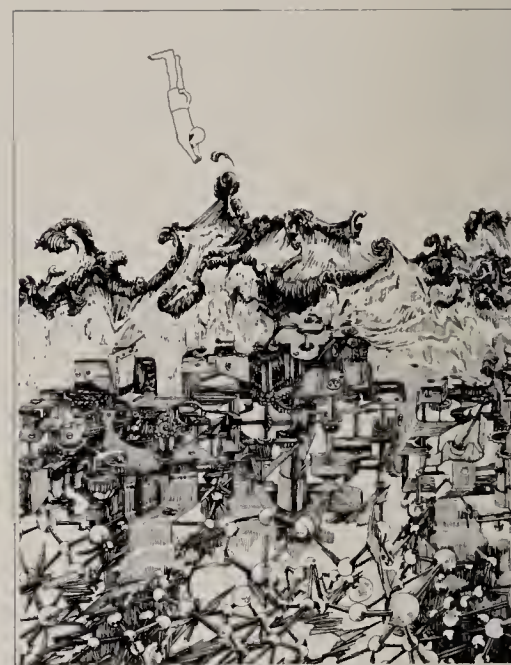
The book may be ordered from Brunner/Majel, Inc., 19 Union Square, New York, N.Y. 10003.

TRENDS

(Continued from page 23.)

the first time in 5 years at a time when continued retrenchments due to inflationary trends in the economy might have been expected. The suggestion of a trend away from "expensive" cases, *i.e.*, the severely disabled, could be a factor behind the increase in intake activity. What has been established, nevertheless, is that ever-increasing numbers of severely disabled people, whether in absolute or relative terms, can no longer be taken for granted.

Mr. Mars is Senior Statistician, Division of Program Data and Analysis, RSA.



15 MILLION PEOPLE ARE NOW DISABLED BY ACCIDENTS AT WORK

Drawings by Hans Georg Rauch, Federal Republic of Germany.

RESEARCH

(Continued from page 25.)

treatment being considered in the broad sense to include medical, education, and psycho-social services to children and their families). The principal objectives are concerned with demonstration, research, evaluation, and use.

The four principal objectives are: (1) Develop and demonstrate a model early intervention program appropriate for a rural setting that has the following three components: prevention, early identification, and rural services outreach and communication network; (2) conduct research to produce new information related to each of the three program components; (3) evaluate the effectiveness of the model program; and (4) use the information and experience gained from Objectives 1-3 to: inform professional and lay audiences about the most effective ways to prevent and to intervene with severely handicapped and high risk young children and train others in the use of the most effective procedures.

ACCESS AMERICA

Carl Goodman

Reagan Administration Seeks No Funds In '82 For ATBCB

The Reagan Administration has recommended to Congress that the ATBCB not be funded in fiscal year 1982. Without funding, the agency would cease to exist October 1, 1981. The Carter Administration recommended \$2.3 million for the ATBCB. The agency has 24 staff and is authorized \$3 million through fiscal year 1982.

Deaf Administrator Appointed To Board

David W. Myers of Baton Rouge, La., coordinator of that state's services to deaf and hearing impaired citizens, is the newest public member of the federal Architectural and Transportation Barriers Compliance Board (ATBCB).

Myers joins 10 other citizen members on the federal panel Congress created in 1973 to enforce the Architectural Barriers Act, federal law requiring access for handicapped people to and in most federal and federally funded buildings and facilities.

Myers, 44, deafened by spinal meningitis at age 8, was appointed by President Carter January 18. One of nine public members who is disabled, Myers' term expires December 3, 1983.

A native of Winston-Salem, N.C., Myers began his career in vocational rehabilitation in Raleigh in 1964, and he has devoted his professional life to rehabilitating deaf and hearing impaired people in North Carolina, Indiana, Ohio, and Louisiana.

Myers joined Louisiana's rehabilitation services in 1970, starting as a counselor in New Orleans and moving to Baton Rouge in 1974 as a program supervisor.

Myers also serves on the board of the American Deafness and Rehabilitation Association and is past secretary-treasurer of the National Association of the Deaf. He is a former president of the Louisiana Association of the Deaf. He is in the Louisiana Registry of Interpreters for the Deaf.

The new board member earned a bachelor's degree at Gallaudet College in Washington, D.C., in 1961 and a master's degree at California State University at Northridge in 1969. He has also studied at the University of North Carolina at Chapel Hill and San Francisco State College.

Delaware Adopts Board's Guidelines

The State of Delaware has adopted with modifications the board's minimum guidelines and requirements for accessibility in federally funded buildings and facilities, published as a final rule in the January 16 *Federal Register*.

Delaware's nine-member Architectural Accessibility Board adopted the guidelines unanimously February 19 while meeting in Wilmington. They are effective June 1, 1981.

Created by the Architectural Accessibility Act of 1979, the board began operations in December of that year. The board's members are appointed by the governor to 4-year terms. At least four members must be disabled, including one wheelchair user. One member may be a guardian of a disabled person or representative of disabled persons. There must also be an attorney, architect, engineer, and a contractor experienced in commercial construction.

The state agency is charged with assuring that all state owned, leased, and financed buildings and facilities are safely accessible to and usable by handicapped people.

A. Laurence Field, chief administrator of the board, said the new Delaware standard is "99 percent federal." Examples of exceptions include the height of stair risers, the number of accessible listening and viewing locations, and requirements for telecommunications devices for deaf people.

Field said the ATBCB was "very helpful" to Delaware in developing its guidelines. Delaware's process, he said, paralleled the ATBCB's, including using the ATBCB's illustrations in proposed guidelines published for public comment in December 1980. Field said public hearings were held January 5-7 in each of the state's three counties and that copies of the proposed standard were circulated widely among disabled groups, architects, engineers, and other people. Public comments were accepted through January 15, 1981, just one day before the ATBCB published its final rule.

Field said Delaware's accessibility board, chaired by Wilmington attorney Stanley T. Czajkowski, incorporated most of the ATBCB's final regulation into its own with a "fair amount of enthusiasm."

Like the ATBCB, Delaware considers its standard a "living" document, one that will be revised periodically to reflect the latest technology and information. Field said the board is looking to the ATBCB for additional research into communications barriers to incorporate into its own standard.

Field said Delaware faces the prospect of eventually having one standard for all public buildings at all levels—federal, state, and local.

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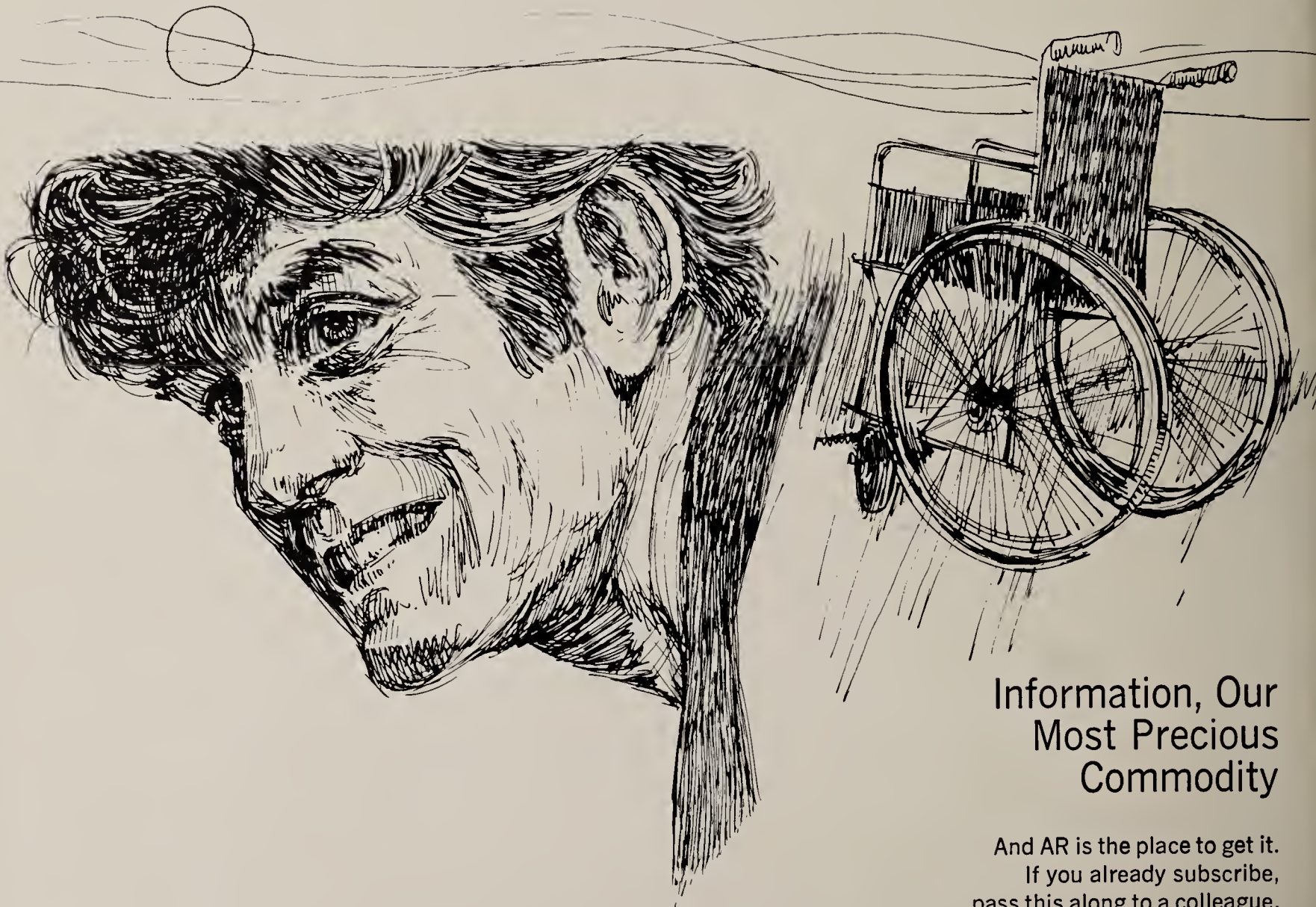
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AMERICAN REHABILITATION



Aide Training



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AMERICAN REHABILITATION

Volume 6, Number 6 The weakest ink is better than the strongest memory. **July—August 1981**

3	The Disabled Entrepreneur	Charles S. Richman
7	Job Club and Transferable Skills	Pamela Kauss and Maria Soto
12	Pilot's Layover Hobby	Jacqueline Gendar
13	Jolly Well Done, Old Chap	Lam Man-Kit
18	Cooperative Occupational Preparation Of The Handicapped	Gerard J. Bensberg, Ph.D., and Sylvia Ashby
23	Potpourri Of Deaf-related Journals	Nidia Moreno Milne, Ph.D.
28	Community Based Attendant Care	Homer Page, Ph.D.

DEPARTMENTS

2	Topic of State	15	Language Used	Cover Painting: Antoinette Agnew Reynolds
6	IYDP	16	Notes On The Margin	
		32	Report Resources	

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TOPIC OF STATE

Wisc. City Accent On Parking For Disabled People

The City of Kenosha, Wisconsin has created a general ordinance to regulate signs for handicapped parking lots. The committee on Public Safety and Welfare was responsible for the ordinance.

The ordinance reads: Effective June 1, 1981, all parking lots having parking places which are required to be provided by law for the handicapped shall be posted as herein described by the person or party thereof. The person or party in charge thereof is defined as a tenant holding under a written agreement, or, if there is none, the owner. Posting shall be by one or more appropriate, permanent signs totaling at least one square foot in size, the bottom of which sign shall be at least five feet above the immediate surface of the parking lot located at the center of each parking space which is reserved for the handicapped. Said sign or signs shall indicate that said parking place is reserved for the handicapped and shall state the penalty for unlawful parking therein. Each day after June 1, 1981, during which this ordinance is complied with, shall be a separate and continuing offense. This ordinance shall apply to parking lots which are existing on or which are constructed after June 1, 1981.

Frank Marrelli, Director of Architectural Barriers in Parking for ABLE in Kenosha was responsible for the initiation of this bill. He states, "I've been working for a number of years to strengthen handicapped parking in
2 Kenosha and to make the Police De-

partment aware that they can ticket cars illegally parked on private property in designated spaces."

"Finally," states Marrelli, "a large city in Wisconsin has gotten a law on the books that will stipulate how designated parking shall be posted." Marrelli states that he is now working with local representatives to sponsor a bill at the state level, which will also include a stipulation that all designated spaces will be 12 feet wide instead the present 8 feet.

Wisconsin DVR Newsletter

Pa. VR Agency And Labor Dept. Sign Agreement

On December 1st, the Pennsylvania Department of Labor and Industry's Bureau of Vocational Rehabilitation entered into an agreement with the Allegheny County Commissioners to provide training and employment services for Comprehensive Employment Training Act—eligible County residents who are handicapped and considered employable in unsubsidized employment.

Signing the pact were Secretary of Labor and Industry Charles J. Lieberth; county Commission Chairman Tom Foerster; John Galik, District Administrator of BVR's Pittsburgh office; and Bernard J. Powers, Director of the County Division of Federal Programs.

The agreement is thought to be the first ever between the U.S. Department of Labor and a state vocational rehabilitation agency. It is intended to provide 525 handicapped residents of

the county with personal work adjustment training (PWAT), public service employment, and on-the-job training. It also establishes a direct referral system, through which the Department of Labor and Industry will refer handicapped persons to the regular DFP programs.

PWAT will be provided through contracts between BVR and six Pittsburgh-area agencies: Association for Children with Learning Disabilities, Council House, Easter Seal, Goodwill, Pennsylvania Association for Retarded Citizens, and the Vocational Rehabilitation Center.

The enrollees in this program will be assessed, pre-screened, counseled, and medically examined, prior to participation, to increase their potential for completing the program and eventual employment.

—Success, Pennsylvania Bureau of Vocational Rehabilitation.

DD Council Shares Telecommunications

The New Jersey Developmental Disabilities Council has become one of the first state councils to participate in a nationwide telecommunications system that links University Affiliated Facilities (UAFs). If the demonstration project to test the feasibility of linking councils, in addition to UAFs, with a computer network proves successful, the National Association of Developmental Disabilities Councils will explore extending the system to include developmental disabilities councils nationwide.

Interface, N.J. DD Council.

The Disabled Entrepreneur

Charles S. Richman

Many observers of the American economy predict that entrepreneurs and small businesses will blossom in the '80's. The recent 1980 White House Conference on Small Business heralded this revival and renaissance as the "coming entrepreneurial decade." "There is a tide in the spirit of individual enterprise in America, and it is rising . . . More and more Americans are eager to start small, independent businesses . . . More and more are deciding that only through ventures of their own can they achieve the kind and quality of life that they envision."¹

After more than a half century of decline, small businesses have once again begun to rival big business and big government in economic importance. There are now some 12 million small business concerns (with a half million new incorporations being added annually); furthermore, recent studies show that about two-thirds of all new jobs in the economy are created within small firms. Other statistics show that after 2 decades of decline, some 8 million American workers were classified as self-employed last year (a 25 percent increase since 1972). Another 2 million salaried owners of incorporated small businesses considered themselves self-employed (a 41 percent increase

since 1976), and almost 1½ million workers moonlighted in self-employment as second jobs.

The New Industrial Heroes—Entrepreneurs

Just a few years ago the term "entrepreneur" was rarely used in everyday language and was seldom seen in print. Today, hundreds of colleges and universities offer courses on entrepreneurship and venture capital. Scores of self-help books and how-to-do-it manuals on small business opportunities and small business management fill local bookshop displays, and several specialized magazines are available nationally that cater to budding small business people.

In a recent issue of *Venture*, "the Magazine for Entrepreneurs," the term "entrepreneur" was used some 89 times in its 80-page January edition. The word first entered the English language from the French in the Middle Ages. In the 15th century *Book of Nobleness*, "entrepreneur" meant "champion." Through the years, the term came to mean a businessman who organizes and manages a business concern, assuming risk for the sake of profit. In recent days, the "entrepreneur" has acquired the reputation for being an innovator and creative risk-taker. As the new industrial hero, the "entrepreneur" has become a modern-day champion of business revitalization and reindustrialization in America. Underlying it all, is a new social consensus in our country which wants the entrepreneur to succeed and rekindle the American dream of self-reliance and free enterprise.

The "entrepreneur" can be found in many types of business, including not only small business concerns per se, but also in self-employment through free-lance consulting, professions, trades, farms, or other inde-

pendent employment. They may operate within small incorporated businesses or in unincorporated ventures and professions throughout all sectors of our economy (retail, wholesale, manufacturing, and service industries).

State VR Small Business Enterprise Programs

Surprisingly, the best estimates available (based on the 1970 Census) indicate that there are nearly 900,000 self-employed people with work disabilities. Disabled entrepreneurs have proven themselves to be successful in almost every professional field and in practically every line of business. Each year some 8,000 disabled clients (about 3 percent of all rehabilitants) are placed into self employment by the state vocational rehabilitation services program. The state programs assist disabled entrepreneurs through their small business enterprises programs.

Since the inception of the state-federal vocational rehabilitation program in 1920, thousands of disabled people have been helped to establish businesses of all kinds. Financial, managerial, educational, and technical assistance services have been rendered in order to help disabled entrepreneurs enter into sales, clerical, professional, services, farming, and industrial self-employment. Specific occupations of self-employed rehabilitants have included jobs in architecture, medical and health careers, entertainment, management, retail sales, barbering and cosmetology, and a wide variety of other trades and professions. In addition, last year, almost 4,000 blind vendors participated in the Randolph-Sheppard Vending Facility Program.

One of the most comprehensive state programs available to disabled entrepreneurs is the Business Oppor-

tunities Program of the California Department of Rehabilitation. This program was highlighted in an article on self-employment appearing in *American Rehabilitation*.² This account details a number of innovative projects attempted by the California VR program. One such project was the effort to convert a part of the Los Angeles County administrative building's cafeteria to an arcade for disabled-owned businesses. Another project mentioned in the article was the establishment of a special unit within the Department to provide technical assistance and other advice to field counselors not fully acquainted with self-employment opportunities and resources. Other state VR agencies have also developed creative approaches to small business enterprise development for their disabled clients. An example of just one such approach is the development of a cassette tape small business practices course by the West Virginia State Board of Education, Division of Vocational Rehabilitation. This course is used to supplement training and other financial, legal, and management assistance provided by the West Virginia VR agency.

Unfortunately, many state VR agencies discourage self-employment by their clients. This is because of the well-publicized failure rate of small businesses as well as the extent of start-up costs necessary to finance the establishment of a new small business. In many agencies it is the stated policy to consider placement of clients into self-employment as a placement of last resort. In these programs, placement in salaried competitive employment must be considered before self-employment possibilities may be explored. Most state VR agency small business enterprises programs also impose severe

4 (and some say unrealistic) limits on

the extent of direct financial help available to eligible disabled entrepreneurs.

A recent effort to recognize the capabilities of disabled entrepreneurs is authority provided under Section 622 of the "Rehabilitation Act Amendments of 1978." Under this newly conceived program, called "Business Opportunities for Handicapped Individuals," federal grants and contracts may be received by handicapped people. This assistance is designed to help disabled entrepreneurs to establish and operate commercial or other enterprises and to develop or market their products or services. Unlike most other rehabilitation service programs, Section 622 is not to provide rehabilitative services but rather to assist in opening up business opportunities for disabled entrepreneurs. (Note: At the time of publication, funding for the Section 622 Program was still pending for FY 1981. Actual implementation of the program will depend upon this funding.)

Some Other Help for Disabled Entrepreneurs

There are a number of other sources of specialized governmental help and private sector help for disabled entrepreneurs that should be mentioned. Foremost and most important of these is the Handicapped Assistance Loan Program (HAL) sponsored by the U.S. Small Business Administration. Since 1973, more than \$90 million in low interest loans have been extended to sheltered workshops (under the HAL-I Program) and to individual disabled entrepreneurs (under the HAL-II Program). Each year, HAL 3-percent loans (averaging about \$75,000 each) go to hundreds of disabled entrepreneurs. This program has proven to be so popular that there is an extensive waiting list of approved loans to dis-

abled entrepreneurs which are awaiting funding.³

Other, more general governmental help for small business establishments (including educational and training assistance, technical and management assistance, financial assistance, and procurement assistance) may also be available. Such federal agencies as the U.S. Departments of Agriculture, Commerce, Education, and Labor, as well as the Small Business Administration and General Services Administration, have numerous programs to support and assist entrepreneurs (including disabled entrepreneurs). Many state and local governments were also beginning to provide financial and other help to entrepreneurs. Nearly 20 states have passed special legislation or formed special committees to encourage small business establishment.⁴

An extensive private sector support system also exists to provide information, training, and consultant or other services to all entrepreneurs. Although currently quite limited, there are also some specialized assistance programs for disabled entrepreneurs through private sector auspices. One such resource is Independent Visually Impaired Entrepreneurs (IVIE), an affiliated organization of the American Council of the Blind. This group, which is currently getting organized, is composed of blind entrepreneurs interested in independent small business opportunities.⁵ Another example of a group specializing in helping and promoting disabled entrepreneurs is the Association of Handicapped Artists which helps artists hold art exhibits and market their work.⁶

For many years, *Accent on Living Magazine* has publicized disabled entrepreneurs and provided disabled people with information on how to get started in their own businesses. This has included a particular focus

on home-based businesses opportunities for severely disabled entrepreneurs.⁷ Without knowledge, education, and experience, disabled entrepreneurs are not likely to succeed in their small business ventures. Up to now, educational and training opportunities for disabled entrepreneurs have been largely nonexistent. There is slowly developing, however, an interest in preparing special management assistance for disabled business owners. One such university program is sponsored by the University of New Haven, School of Business Administration. Under the university's new Small Business Institute Program, the development of small business opportunities by potential disabled entrepreneurs will be stimulated and assisted.

The Decade Ahead

Self-employment and entrepreneurship offer disabled people a host of new and unthought-of opportunities for employment in the 1980's. These opportunities are not only financial ones, but also opportunities for self-fulfillment and self-development. In a world of occupational stereotypes, many disabled workers confront continuing barriers to attaining fulfilling employment. There are almost 8 million disabled people who are either unemployed or out of the labor force. As many as 2 million disabled workers who are working are underemployed in marginal employment situations. Employment data indicate that employed disabled workers are often relegated to low-paying and often menial jobs (the so-called "secondary labor market"). There is no question that in today's labor market, for one reason or another, the talents and productivity of disabled workers are underused.

Self-employment may provide a new avenue towards employment of

thousands of talented and capable disabled entrepreneurs. Despite the obvious lack of labor market demand for their talents, little public policy interest and private help has been extended to the disabled entrepreneur. Negative occupational stereotypes or other prejudices have diminished the credibility and potential success of many disabled entrepreneurs. Much more help is necessary to assist competent disabled entrepreneurs to find financing, management and technical services, and business education or training.

A number of trends may increase the number of disabled entrepreneurs entering into self-employment. The service-oriented economy, computer technology and telecommunications, and the growing consumer consciousness of many disabled people will lead many of them to self-employment situations. With current trends in information technology and communications, in the next decade, the home computer will help to create the "electronic cottage." Many severely disabled workers will be able to acquire lucrative self-employment within their own homes.

Furthermore, self-help and consumer groups, composed of capable disabled workers, will increasingly operate group entrepreneurial ventures. Such ventures will be organized as co-operatives, profit-making concerns, nonprofits or other combined efforts. Many groups of disabled workers may also seek to develop locally controlled and operated community development corporations. These corporations will invest public and private dollars in income and job-producing enterprises. In the 1960's, "black capitalism" sought to integrate black entrepreneurs into the mainstream of small business ownership. This was followed by efforts in the 1970's to move women entrepre-

neurs into small business careers. The 1980's may well become the decade of independence for the disabled entrepreneur.

Mr. Richman is a human services consultant. He is the author of *Small Business Enterprises for Workers with Disabilities* (see Note 4).

Notes and References

1) *Report To The President, America's Small Business Economy—Agenda For Action*, White House Commission On Small Business, Washington: Government Printing Office, April 1980, 9.

2) Coletti, Edward J., "Self-Employment For Severely Disabled People", *American Rehabilitation*, Washington: Rehabilitation Services Administration, Vol. 3, No. 1, September–October 1977, 6–11.

3) For more information on the SBA Handicapped Assistance Loan Program contact your local or regional Small Business Administration Office.

4) Additional information on a variety of sources of help in setting up small business enterprises can be found in *Small Business Enterprises for Workers with Disabilities* expected to be available in the Spring of 1982 from the Institute for Information Studies, Falls Church, Virginia.

5) For further details, contact the American Council of the Blind, 1211 Connecticut Avenue, N.W., Suite 506, Washington, D.C. 20036.

6) Further information on this organization available from the Association of Handicapped Artists, 1034 Rand Building, Buffalo, New York 14203.

7) Cheever, Raymond G., editor, *Home Operated Business Opportunities for the Disabled*, Bloomington, Illinois: Accent Special Publications, Cheever Publishing, Inc., 1977.

By Ned Burman

IYDP News And Notes From Here and There

News of the International Year of Disabled Persons will be given added emphasis during 1981. In keeping with the IYDP theme of full participation for all people with disabilities, this column will carry news of significance to handicapped persons.

The Winter Park Handicap Recreational Program in Winter Park, Colorado, began to teach people with amputations to ski in 1971. Now, people with 29 different types of disability are also taught to ski. At some winter resorts, a blind skier may take to the slopes in tandem with a sighted companion. Other skiers may require outrigger skis to give them balance. Beginning ice skaters may use a skate aid for support until they gain confidence.

At *Borderland Farm* in Warwick, New York (the home of Winslow Riding for the Handicapped Foundation) persons of all ages, with all types of disabilities are welcome to ride provided they have medical or other professional clearance. Riders wear protective helmets that look like jockey caps. They receive individual instruction and progress at their own pace. Training and certification for riding instructors to teach disabled persons is provided by the North American Riding for the Handicapped Association.

In South Wales, a regular worker in a factory spends three months with a new mentally retarded worker, giving help and solving problems. The worker receives extra pay for these services.

In Tunisia, a retarded worker
6 who is ready for employment plunges

right into the regular labor force; no half-way steps.

In Sweden, "work enclosures," special areas of a plant or office have been set aside for the training of retarded people and are meeting with success—as in the VOLVO automobile plants.

In Kenya, 90 percent of retarded citizens live in the countryside and tend cattle and do farm chores. Each person is trained to work with his own hands.

A recent study shows 75 percent of the nation's mentally retarded adults can hold jobs, with proper training, orientation and a little extra supervision. Their motivation and performance rank high. Quit rates, absenteeisms, tardiness, and safety rates are often better than non-retarded workers.

United Nations sources claim world-wide support for IYDP 1981. The latest tally shows 86 countries have IYDP committees and have announced planning activities for the year.

Special Edition Focus On Alcohol In Disabled People

The Winter 1980/81 edition (Volume 5, Number 2) of *Alcohol Health And Research World*, published by the National Institute On Alcohol Abuse and Alcoholism, devotes its

entirety to the subject of substance abuse and the handicapped person.

It is a comprehensive and indepth survey that would probably be of much interest to many workers in the rehabilitation field. As such, it develops statements on a number of policy issues, intergovernmental relationships, and a comprehensive coverage of alcoholism-related topics dealing with counseling, community linkages, and categorical disabilities and the special problems that arise in them through substance abuse.

The publication also carries interviews with a number of national leaders both inside and out of government, such as Frederick Sachs of the Rehabilitation Services Administration and Frank Bowe of the American Coalition of Citizens with Disabilities.

Single copies of the magazine are available through the Superintendent of Documents, P.O. Box 1533, Washington, D.C. 20402. Price is \$1.75 per copy and \$2.20 when ordered from a foreign country.

The Economic Benefit Of VR

Benefits to People

Life-time earnings estimates people rehabilitated by state rehabilitation agencies in fiscal year 1979 will improve by \$11 for every dollar spent on services for all clients whose cases were closed in that year. This is the third time in the last 4 years that the 11:1 ratio has been projected. This means that state agencies, through the placement of disabled people into increasingly higher paying jobs, have been able to neutralize the effects of rising costs, declining numbers of re-

(Continued on page 27.)

Job Club And Transferable Skills: Models For Placement Of Severely Handicapped

Pamela Kauss And Maria Soto

Gainful employment is one of the most important aspects of a person's life. Employment serves not only as a foundation for social status and economic security but is also at the heart of self-esteem and self-concept. Work underpins basic feelings about one's self and one's personal worth. Despite universal recognition of this relationship, until recently there was no definite program of training in how to locate appropriate, gainful employment. In recent years, with the growth of the career education movement, there has come into being a multitude of resources about career awareness, career exploration, career preparation, and career information.^{1,2,3,4,5,6,7}

Even though there has been a proliferation of books and articles regarding job seeking skills, writing a resume, completing an application, and performing on an interview^{8,9,10,11,12,13,14,15,16,17} there appears to be a dearth of empirical evidence to indicate whether any of these work.

Like their able-bodied counterparts, disabled people have had limited exposure to aspects of career exploration and few career resources have thus far been adapted for them. After reading articles and technical papers by Nathan Azrin^{18,19,20,21,22} in which he described his behavior therapy-based job finding club and its

success, the authors of this article felt this method could be beneficial for disabled clients who were seeking employment through a state-federal vocational rehabilitation program.

This article discusses experiences and challenges in setting up a job finding club for the disabled. It also discusses a project related to the job finding club that assesses transferable skills and assists the disabled with a speedy return to work.

The job finding club was developed, tested, and refined by Nathan Azrin, Ph.D., and his associates. It is a behavior therapy model derived from the field of psychology known as learning theory. The emphasis in job club is on standardized procedures, modeling, behavior rehearsal, feedback, positive reinforcement, and results. The people participating in job club considers the job search as a full time job. They are expected to be looking for work when not engaged in the group activities of job club. Friends and relatives are included in the process and emphasized as a source of encouragement and job leads. Most aspects of the search are standardized, and behavioral scripts are available for making phone calls, writing letters, and answering interview questions. The job club provides assistance and encouragement for the job seeker. Support is provided by

sharing job leads, transportation, and a listening group of co-job seekers. In short, the job club participant 'learns' the skills and behaviors needed to find work.

After learning about the style, features, and purpose of job club, the authors felt this approach had much to offer in the Department of Rehabilitation. Typically, disabled clients were trained for employment and then expected to find their own jobs, with little or no comprehensive job search instruction. It was felt job club could provide an approach and an atmosphere where appropriate methods of locating employment could be learned. The goal would be teaching skills that could be used over and over during the course of a disabled person's work life.

Job club began in March 1979, with five clients and five counselors who volunteered time away from their caseloads in order to facilitate job club. It met twice a week, Monday and Wednesday, instead of daily (as per Azrin's model) for a number of reasons. Because its leaders were also full time counselors with caseload responsibilities, they did not have every morning free to lead the club. Secondly, due to the size of Los Angeles and the great distances and time involved in travel, it was felt that meeting every day would leave little time

for interviews. Another consideration was the severity of the client's disabilities. Many of them relied on attendants and/or drivers for transportation, and having three full days to look for work made it easier on them both physically and in terms of scheduling. Other than the time change, Azrin's model was followed as closely as possible. Scripts were made, skills were taught, and all staff tried to remain positive, directive, and encouraging. Within a few weeks, a supportive atmosphere developed in the group and members began to assist each other and share job lead information.

Fourteen job clubs have now been completed. A new one is started on the first Wednesday of each month in the afternoon and clients are involved every Monday and Wednesday morning thereafter until they have found employment.

The results of job club involvement have been productive for both clients and counselors. Most important are the feelings of the clients and the outcomes that participation has helped them achieve. By way of illustration, the cases of three members are presented below in terms of disability, job club assistance, and vocational accomplishments.

Jim was in his mid-thirties and had a disability of paraplegia due to transverse myelitis, onset May 1971. Before the onset of his disability, he had been a high school teacher. Because of his wheelchair and a resultant loss of self-esteem and confidence, he did not want to return to teaching. He had spent the last few years volunteering at an independent living center. When he first came to job club, he could hardly maintain eye contact with the rehabilitation counselor, spoke in low tones, and did not know what he could do or what skills he had. Al-

though he was able to offer excellent suggestions for dealing with the problems of other clients, he could not deal effectively with his own vocational goal. He had wanted to become employed by the state as a rehabilitation counselor in the Department of Rehabilitation. Prior to job club, he had gone through the civil service process twice, but each time failed to pass the oral interview.

Goals in job club included teaching him how to interview and how to rewrite his resume so that it reflected the skills he had acquired at the independent living center. It was felt that it was important for him to recognize the things he had learned as a volunteer and consider them as valuable assets and transferable to another job. His resume was rewritten to accent his range of skills without mention of his disability. By participating in job club, he became more outgoing and involved with the other members of the group. Because of his new resume and his increased skill at interviewing, he became more self-confident and more involved in the role of assistant to the job club leader. Jim also began to help the other clients with their job searches. There were two non-verbal communicators in the group, so Jim would make their phone calls and set up interviews for them. As he became more adept in the role of job club leader, the rehabilitation counselors gradually withdrew as facilitators and he became the leader of the group.

Within 3 months, there was another state examination for the position of rehabilitation counselor trainee, and Jim signed up for the test. Armed with his newly acquired interview skills, his new comprehensive resume, and his recent experience in running a placement group for the disabled, he took the examination and scored 98 out of 100 on the test. Within 6 weeks, he was placed in an

office, and he has been promoted from the position of trainee to journeyman counselor. Jim is an excellent example of a young man who did not need more training or intensive counseling. He did need a new way of looking at his ability, his skills, and what he had to offer. Once he gained a new view of himself, his skills, competency, and caring took over, and he was able to locate employment.

Jay was a 55-year-old man with a history of diabetes and nervous disorders. He had been a client of the Department of Rehabilitation for several years before he was referred to job club. He had just completed his Bachelor of Arts in business management and wanted to find a job. He had worked most of his life, until the onset of his disability, and he was concerned about being unemployed. He was almost frozen by concerns about his age and disability. He was older than most members of his job club and brought up his age frequently as the reason no one would hire him. His age was consistently ignored by the rehabilitation counselor facilitator and his skills and background were consistently emphasized.

A resume was prepared and interview behavior was modeled and rehearsed. From his initial attitude of "poor old me," he moved into the role of helper and encourager of other, younger clients. He attended local job fairs, sent out resumes, spoke with friends, relatives, and acquaintances, and eventually obtained an interview at a major electronics firm. His interview was successful and he was hired at a starting salary of \$25 thousand per year. He has been employed about a year now, and, whenever he can, he attends job club and shares his experiences, encouraging current members to stay positive and to participate in the job

search process. He has become a very self-confident man, a good employee, and feels that his age is no longer a barrier.

Janice was a 39-year-old, incomplete quadriplegic as a result of an automobile accident in November 1972. She had training and experience in graphic arts and wanted to continue to work in the field. She was able to do the work but could not tolerate pressure or stress. Because of her disability and her feelings about it, she did not sit straight in her chair, had a tendency to look down and fold her arms, and totally withdrew from other people. Her other problem area was her resume. The counselors felt that her resume, viewed as a work of art, could provide a statement about her ability as an artist. Effective interview behavior was modeled and rehearsed. Over time, she learned how to be comfortable in an interview setting. Her resume took hours to prepare and was finally completed with the use of graphics, diagonal lines, and grey paper. It was quite striking and she received many compliments on it during her job interviews. She was able to obtain employment as a graphic artist in a small company with steady business and very few rush orders.

These cases represent what is commonplace in job club. Modeling and behavioral rehearsal are critical parts of learning how to find a job. A positive approach is also essential. It is exciting to see the growth and positive feelings about work skills as disabled clients began to see themselves as qualified job applicants. Having a professional resume and appropriate skills have given many clients the push needed to go out, talk about themselves, and get hired. Employed clients do not usually forget other people in job club. Many will return before starting their new job to en-

courage the remaining members and urge them not to give up. Several have provided employment leads for other members.

A group comradery spontaneously developed in each group. No attempt was made to force relationships or friendships, but in the positive, upbeat, involved environment, assistance and support was a natural outgrowth.

As of December 1980, 12 job club groups had been started. There were 142 clients who participated regularly and as of the end of March 1981, 86 clients, or 61 percent had become employed. All groups consisted of clients who were disabled because of physical problems, emotional problems, or a combination of the two.

One of the unexpected benefits of the job club was its effect on counselors' morale. Initially, job club was started to provide assistance to clients and only two rehabilitation counselors were to be involved each day. All rehabilitation counselors became so involved that many of them wanted to help out on days when they were not scheduled to participate. The clients consequently were exposed to five professionals consistently assisting them with their job search. By increasing the number of counselors looking for him/her, each client was now considering more options and was exposed to a broader environment and range of employment possibilities.

A second unexpected benefit was that counselors began to assist one another and share job leads. Prior to job club, a specific job lead was usually kept by the counselor who had received it and used exclusively for his/her clients. Within a few weeks of job club's inception, counselors were meeting in the hallways and sharing information so that all clients in job club would benefit. Sharing and help-

ing one another was very important to the morale of the office, and a mutual respect developed among counseling staff. It was commonplace for counselors to be running up the hallway looking for someone with whom to share a good job lead.

Another counselor-related outcome was an increased knowledge of the world of work and the labor market. Staff felt that by being so involved in the final phase of the rehabilitation process—placement—they were very aware of what jobs were available and what jobs were more difficult to locate. This information could be used in the beginning phase of the rehabilitation process—goal selection—and clients would no longer be placed in training for jobs that did not exist in sufficient numbers in the labor market. For instance, clients trained for "landscaping jobs" were very prevalent in the first few job clubs, but it was discovered that there was no demand for landscapers who could not work independently and carry heavy equipment. The counselors learned from this experience, and now only clients who had the ability to work alone and carry heavy garden equipment are referred to job club as landscapers. Intense participation with placement had paid off in terms of better planning for jobs that were available and present in the community.

One final benefit for counselors was the increased confidence that resulted with regard to placement activities. Placement-related tasks traditionally had been the "least favorite" job of the rehabilitation counselor and one for which he/she had little training or exposure. In the job club program, counselors were constantly discussing appropriate work behavior and dealing with world-of-work issues that related to disabled people. In every job club, issues were raised 9

about dealing with disability, accounting for years off work, and mentioning Worker's Compensation injuries and resulting functional limitations. The job club counselors were forced to deal with employment issues and to work with clients on appropriate solutions. Counselors also went with clients on interviews to assist those who could not speak for themselves. For these counselors, placement had become an integral part of their job and one with which they were increasingly comfortable.

Transferable Skills Project

In addition to job club, the authors have been involved with a project to assess and use transferable skills. There was a feeling among staff that many people who applied for vocational rehabilitation services already had skills and abilities that could be used in another job. A method was needed to determine what these skills were and how they could be modified to be used in a new employment situation. By thoroughly assessing and cataloging these skills, and then systematically looking for jobs that involved them, it was felt that the clients could return to the work force quickly and save time and money from unnecessary training programs. The goals for this program were established as follows: to collect, analyze, synthesize, and interpret information about transferable skills; to streamline and bypass the "traditional" vocational rehabilitation process in terms of long term training programs and long waiting periods for determining eligibility and beginning a program; to eliminate excess or unnecessary Department of Rehabilitation spending; to save clients time, energy, and frustration by assisting in a quick return to work and less time as an unemployed person; to save welfare/social security funds by cut-

ting time that clients receive these benefits; and to provide quality service.

To accomplish these goals, the project consisted of a team—a rehabilitation counselor and a career technician. The career technician was a clerical person who acted as a paraprofessional assistant to the rehabilitation counselor. The project began in August 1980.

Before the project's start, a 3-month training period was held for 3 intake clerical staff to teach them to identify a transferable skill and to ask questions that would alert them to the existence of such skills in interviewees. A screening sheet was developed, and on Friday each screening sheet from the week was reviewed and discussed. This exercise preceded the program's official start, so that all involved staff had an idea of what was being looked for and what a transferable skill was.

Once it had been determined by the intake screener that an applicant had transferable skills, the client was seen by the career technician. This person did a complete initial interview and scheduled the client to return later that week for a transferable skills group. The applicant left the initial interview with releases and forms to take to his/her doctor and from that moment on was very involved with his/her program.

Twice a week, transferable skills groups were conducted by the rehabilitation counselor and career technician. These groups are not groups in the sense of one agenda for several clients with a facilitator; it was a group of people who worked on their own, trying to select a new vocational goal. The client worked on interest inventories, on skills testing, or on researching vocational literature. The counselor moved from client to client, assisting in whatever area was

needed. The career technician had been trained to administer interest instruments and score them, but the counselor had interpretation responsibilities. The career technician was also involved in clerical skills testing so that assessment could be made of the client's ability to type, file, and acceptably perform other related tasks. The counselor was used for problem solving, goal selection, and assigning appropriate tasks to the client. Once the client knew what his/her skills were, a search began for a goal that matched these skills and was compatible with his/her disability. Tentative goals were researched in terms of labor market supply and demand, job analysis, and labor market surveys. No goal was selected as definite until it was evident that there was a reasonable expectation that a job existed in the field. Once the goal became definite, the client was referred to job club for job placement.

Anywhere in the process, it could be found that the client did not have viable transferable skills or that training was more appropriate. If this occurred, he/she was referred into the traditional rehabilitation program. By this point, medical information and diagnostic information had been accumulated so the new counselor and client could proceed with vocational planning without interruption.

In the 7 months since the project began, the transferable skills project has had 57 referrals, written 26 programs, and closed 7 clients as successfully employed. More important than actual numbers was that, on an average, it took only 37 days from initial interview to program, and 22 days from program to placement. The goal of speedy service delivery was achieved.

Feedback from clients regarding this project has been good. Most clients welcomed the weekly contact

with the counselor and the speed with which they were placed. Many had problems with specific goal selection, employer resistance, and Worker's Compensation issues, and these were main themes of the counseling sessions.

Reaction on the part of the staff regarding the transferable skills program has been mixed. Working as a team was difficult, and both the counselor and career technician had been unclear as to what task was whose responsibility. Weekly meetings with the supervisor were held in order to smooth out these rough edges. The career technician prepared most of the paperwork under supervision of the rehabilitation counselor, so that counselor time could be used in counseling and consultation. The rehabilitation counselor, career technician, and program supervisor worked closely to ensure that the plans were appropriate and followed departmental regulations and guidelines. The rehabilitation counselor provided ongoing input to the career technician to ensure that questions were answered and problems dealt with.

Both projects—Job Club and Transferable Skills—have so far proved to be excellent in terms of helping clients reach their goals of gainful employment and allowing counselors to work together, assist one another, and pool resources in order to help clients. Clients are now referred to as “our” clients instead of “my” clients, and everyone benefits from this type of attitude. Participation in job club by staff had been voluntary, so rehabilitation counselors who participated were there because they enjoyed and were interested in it.

With the Rehabilitation Act of 1973 and the International Year of the Disabled Person, the disabled are being given more opportunities than

ever before. Both of these programs ensure that the disabled are able to work up to their potential, see themselves as skilled workers, and are able to join society in a productive capacity. Both projects evolved in order to better assist people with goal selection and to teach clients how to locate employment. Both of these goals have been accomplished.

Ms. Kauss and Ms. Soto are both employees of the California Department of Rehabilitation.

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Pilot's Layover Hobby



Captain J.J. Quinn, a 46-year-old father of three, has been flying "the friendly skies of United" for the past two decades. He is a pilot of many talents. When most of his teen-age peers were batting baseballs or making mischief together, young Quinn was tagging along behind his dad, learning how to wield plumbing wrenches to repair leaky faucets and electric water pumps. When he returned from these trips, he started to take small appliances apart to see how they worked. He soon progressed to dismantling toasters, electric irons, radios, televisions, and, finally, even the family car.

"I guess you might say I was a tinkerer at an early age," the soft-spoken, modest Irishman explained.

Today his volunteer "tinkering" has grown into a hobby that has benefitted not only The Lighthouse in New York City, but also other agencies working with visually impaired and handicapped people in Washington, D.C., Cleveland, Ohio, and Alexandria, Virginia.

At The Lighthouse, Quinn's first call to volunteer his unusual service was received by Mrs. Rhoda Hirsch of the braille department. Capt. Quinn asked if The Lighthouse might have some braille machines in need of

repair. In less time than it takes to say "thank you," Mrs. Hirsch accepted his offer.

On his next Manhattan layover, Capt. Quinn found three dust-covered braille writers awaiting his attention. He has now repaired and returned to service six braille writers, and two Sony recording machines.

Capt. Quinn's reputation as a "volunteer extraordinaire" has been gaining momentum around the country. A few years ago, on a layover in the nation's capital, he made a similar telephone call to the Columbia Lighthouse. Again he offered his services. En route to his volunteer assignment, he passed a group of multi-handicapped children in a small classroom setting. He noticed that the chairs in use did not provide enough support for the children's backs. He completed his repair work and returned to his home with a new project in mind.

During nonflying periods, he canvassed chair catalogs for pictures. When he found the sample he wanted, he created and presented to the class eight replicas of the captain's chair.

As an airline pilot, Capt. Quinn, who flew his first solo in a J3 Piper Cub at age 16, has 15 free days off a month from his official duties at United.

It is during these periods that he finds relaxation in his leisure time activities. During another layover in Washington, for example, he learned that a dozen visually impaired men and women wanted to learn to type, but there were not enough typewriters to go around. Capt. Quinn inserted an ad in his local church bulletin, requesting old typewriters "of any condition or age, to be repaired and given to a worthy, nonprofit organization."

(Continued on page 14.)

Jolly Well Done, Old Chap

Lam Man-kit

OXFORD, ENGLAND—Nine years ago Stevenson Fung told officials of the Education Department in Hongkong that he wanted to study physics at a university. The official said that he was mad. He told his friends about his ambition. They advised him to give up the idea. Today, after much hard work, Fung holds a doctoral degree in experimental physics from Oxford and is working on a two-year fellowship at the university.

Fung is no ordinary student. This is so not only because of his academic brilliance and strong will to strive for what he aspires to become. He is blind.

Born 29 years ago as the oldest child of a family of 12 in Hongkong, Fung had normal eyesight and led an early life little different from other children's. Troubles began during his primary school years. He could not see well and had difficulty in keeping up with his studies. Nobody realized his problem. His teachers attributed his lack of progress to something quite different. They thought he was mentally retarded.

Because of his poor performance, Fung did not have the opportunity of taking part in the highly competitive Secondary School Entrance Examination. Meanwhile, his vision deteriorated further. He went to a government clinic for a checkup. The doctors there told him that he was suffering from retinitis pigmentosa—an eye disease that affects the patient's vision through changes in

pigments in the retina, the light-sensitive layer inside the eye. The doctors decided that he was legally blind.

Fung was sent to a school for the blind to learn braille. "It came as a shock as, all of a sudden, I found myself in a completely different environment," he said.

Three years later Fung completed his course. There were two options open to him: he could go to either a blind people's workshop to learn how to make baskets or a vocational training center to be trained as a telephone operator. He chose the latter. At the same time he went to night classes to learn English, using braille books that he borrowed from the Hongkong Society for the Blind.

After his training there, he was employed as a telephone operator by the Customs and Excise Service. But his ambition was to read physics at a university.

"I had a strong ambition to improve my future. The barrier was my lack of sight. But I decided that this shouldn't be my obstacle at all," Fung said. "I'm interested in physics because I've lost my sight since I was young. I've always been interested in the state of matters surrounding me."

There was nobody to help Fung, neither the Education Department nor the school that Fung had attended. Fung said it was quite understandable, as blind people getting passes in examinations in physics and mathematics at ordinary and advanced

levels was something unheard of in Hongkong.

"In the end I convinced myself that the only way to do it was to study privately, without any teaching, in the evenings after work. The only help I got in Hongkong was from an examination syllabus that I bought at a bookstore," he said.

From the braille library of the Royal National Institute for the Blind in London, Fung managed to obtain a number of textbooks on the subjects he was studying. After 18 months of hard work, often with 18- to 20-hour days, Fung took the University of London General Certificate of Education examinations in Hongkong. He got seven "A's" in the ordinary-level examinations and two passes in the advanced-level examinations. He could not take advanced-level physics in Hongkong because there were no laboratories specially equipped for the blind.

In 1972 Fung made a trip to England to explore the various educational possibilities. It was not altogether reassuring. He was told that the most realistic option open to him was to go on a computer programming course. But against his friends' advice, he decided to persevere.

Soon after he returned to Hongkong, Fung learned that he had been given a place at Worcester College for the Blind at Worcester, England, to prepare for the Oxford scholarship examination. There he took advanced-levels again to get higher grades and to cover the wide range of subjects required for university entrance. His hard work paid off 2 years later when he won a scholarship to study physics at Keble College in Oxford. The Royal Commonwealth Society for the Blind also gave financial support throughout his studies.

A place at Oxford did not mean an end to obstacles. Fung's textbooks 13



"I think I have demonstrated unambiguously that, with determination and adequate financial and technical backing, almost anything is possible for the blind," he said. "For the permanently blind, I think the best charity that anybody can give is the appropriate education and training so that they can stand on their own feet."

How did he manage to overcome all the setbacks and excel over many others?

"There's no secret. But there is one thing: you work jolly hard," he said.

Mr. Man-kit is a journalism student at the University of Missouri-Columbia.

PILOT

(Continued from page 12.)

When he checked at the church later he found 14 old battered typewriters waiting for him. He ended up with 10 typewriters that he had restored to running order—enough to launch the new class.

A family man, Quinn, his wife Barbara, and their three children, Kelly, 18, Shannon, 16, and John, 13, live in Annandale, Virginia. To date, Kelly, a student at Notre Dame, is the only Quinn who shares her dad's love of flying.

Now Capt. Quinn is starting a new leisure-time activity and Kelly joins him whenever she is free. "Air-Pix" is the name of his leisure outlet. For what better way could a camera buff, volunteer repairman extraordinaire, and pilot, combine his three loves—but in an aerial photography venture?

Ms. Gendar is Managing Editor, *LH News*, the New York Association for the Blind, New York City. The article is reprinted from her publication.

were too numerous and bulky to be brailled. They had to be put on tape by a team of six readers, and Fung's tape library ran to some 500 cassettes. He has just enough residual sight to be able to read diagrams on a television screen. Practical work was an important part of Fung's course. Much equipment was so constructed that its components and wires could be felt and there were labels in braille. Fung's electronic calculator, was fitted with audible tones to give him a coded reading.

"It's a matter of getting used to the things," Fung said. "A lot of people think experiments must involve a test tube. Nowadays, the results in many experiments are reported in the form of figures, which are analysed by computers. It's only a matter of handling those figures."

In 1977 Fung received a first-class degree. He then decided to embark upon an even more challenging career: he set out to be an experimental physicist, specializing in semiconductors, which are used in electronic devices. He got his doctoral degree in experimental physics last summer.

Fung plans to eventually become a university lecturer. To get the necessary qualifications, he is working on a 2-year postdoctoral fellowship at the Clarendon Laboratory in Oxford. "My aim is to further my research. After my fellowship is over, I'll find a job somewhere. I'll go wherever there are good facilities for research," he said.

Apart from doing research, Fung now gives 5 hours of tutorials a week to 20 students and regularly writes for scientific journals.

Language Used or Used Language?

Obfuscation is a term that defines the art of utilization of many big words so that the pretexts of these words are obscured.

We repeat our often stated position that "Careful writing is more important than simple writing." But careful writing is anything but simple!

"We solicit any recommendations that you wish to make and you may be assured that such recommendations will be given our careful consideration.

"Translation: Please give us your suggestions. We shall consider them carefully."

This was submitted by Sylvia Porter as an example of what she calls "bafflegab." The article ("Clear, Simple Writing Holds Key To Success," *Washington Star*, May 1, 1980) states that "Companies single out 'communications skills' as their most important requirement, ahead of production, financial or marketing abilities." She also quotes Gunning-Mueller principles that we offer here: Keep sentences short; develop your vocabulary; be simple, not complex; avoid extra and unneeded words; use active, not passive verbs; use terms your reader can picture; tie in with your reader's experience; write the way you talk. A conversational tone is one of the best avenues to good writing; make full use of variety; and write to express, not to impress. (Vital!) Present your ideas simply and directly.

We agree with these principles yet are compelled to comment. From our observation of writers in our field, the

injunctions to use the active voice and to avoid unneeded words are cardinal. *It is said that we have actively sought to ostentatiously embellish our written endeavors with nonfunctional appendages that are, perhaps, inoffensive (often almost subliminal) yet that usurp our attention and our spendable time with what, in essence, could be enunciated in a much more efficient and, consequently, conservative manner. We do carry on, don't we?*

METHODOLOGY

We are not surprised at the list's inclusion of vocabulary. The way a word is used is more important than its size. There is nothing wrong with a sentence that says simply what you want it to say. But, also, there is nothing wrong with its sounding and looking good: "The ubiquitous Mr. Doe" is fine; so is "Mr. Doe, the jack-in-the-box." Both are more interesting than a standard, "Mr. Doe is everywhere," if not any more precise. Or was that "the peripatetic Mr. Doe"?

Being simple with a complex thought, however, may be simple minded. A complex thought needs its elements to be presented with order, with planning, with attention, with completeness, and with exposition that may require more than simplicity. In any event and however ex-

pressed, careful writing is most important.

Careful Writing. Simple writing does not necessarily mean clear writing.

Excerpt from an Internal Revenue Service memorandum criticizing the writing style of some of its employees: "The correspondence workload is not only quite heterogenous as respects precipitating factor, issue involved and processing required, but there is also an essential distinction between the majority of items which are neutral or even benign in tone and a lesser portion, but still perceptible volume, which reflects obvious or possible taxpayer dissatisfaction." (The *Washington Star*) Those 52 words could have been expressed in 17: "Our correspondence covers many areas. While most of it is routine, a few letters register taxpayer dissatisfaction."

Bureaucratic Bias (Good words that become vogue and, consequently, vague.) Implement: Has anyone in government started a program? Initiated one? Embarked on one? Opened one? How about inaugurate, introduce, launch, originate, or conceive one? These, and many other words, could be used as the implements for a change of expression. Let's implement the attempt.

Focus and focal point have lost their focus, not to say anything of their point.

Elongationitisism. The simple form is preferred—throw rocks at ro-coco.

... his performance in a working situation—his work performance. (And, depending on what preceded, the word "work" also might be expendable.)

For the purpose of—for or to; in the matter of—regarding or about; from the time of birth—from birth; in an effective manner—effectively.

Notes on the margin...

Facilities resource

Rehabilitation Production Management is a new, national monthly newsletter for sheltered workshops. RPM provides practical, concise information and technical reports designed to help workshops improve their manufacturing capabilities and business practices. Quality control, contract procurement, production scheduling, labor management, marketing, prime manufacturing, time study, and customer relations are just a few of the timely subjects reported on in RPM. In addition, RPM subscribers receive up-to-the-minute listings of nationwide service/commodity contracting opportunities, subcontracting leads, and other business news of particular interest to sheltered workshops. For a sample copy, send \$2 to: RPM, P. O. Box 627, Menomonie, Wisconsin 54751.

Skiing for handicapped

The eighth annual Ski for Light International will be held in the Black Hills of South Dakota, February 7-14, 1982. Ski for Light International, sponsored by HEALTHsports, Inc., in cooperation with the Sons of Norway and the Black Hills Ski for Light Regional Committee, is a week long program designed to introduce visually impaired and other physically disabled adults to cross-country skiing. In 1982, approximately 110 disabled people will take part.

All instruction and skiing is done on a one-to-one basis. Each handicapped person is assigned an experienced, able-bodied cross-country skier, who acts as an instructor/guide for the entire week. In past years, participants have ranged in age from 18 to 67 years with a nearly equal number of men and women.

The approximate cost is \$225 for the week's room and board, based on double occupancy. For an application, write to Trygve Aarsheim, Guide Selection Coordinator, HEALTHsports, Inc., 1455 West Lake Street, Minneapolis, Minnesota 55408. Deadline is November 15, 1981.

Tourist guide to Miami

Miami. See It Like A Native is a brochure by the Metro-Dade Department of Tourism (234 W. Flagler Street, Miami, Florida 33130) that highlights airport, transportation, hotel, restaurant, beaches, parks, and sports activities and localities for the handicapped visitor. The brochure also contains a handy map that locates the described places and activities.

TDD at Space

The Education Services Division at the National Air and Space Museum has acquired a telecommunication device for the deaf (TDD). This machine enables a hearing impaired person to call the National Air and Space Museum to receive information about tours and tour scheduling. The machine has a 24-hour answering service. All messages are returned during business hours. The telephone number for the TDD is (202) 357-2853 (nonvoice). Those wishing general tour and scheduling information should call (202) 357-1400 (voice).

Autism hotline

A national autism hotline has been funded recently by the Maryland DD Law Project under a one-year contract with Autism Services Center of Huntington, West Virginia. The purpose of the new service is to assist in providing advocacy, technical assistance and case management to parents and professionals face with the difficult and often unique needs of people with autism.

The two major goals of the project are to assist in the advocacy activities of parents and professionals who work with autistic people and to give technical assistance in autism to protection and advocacy systems.

More information about the project can be obtained by calling (304) 523-8269 or 525-8014 (call person-to-person, collect) or by writing to National Autism Hotline, 101 Richmond Street, Huntington, West Virginia 25702.

1981

THE INTERNATIONAL YEAR OF DISABLED PERSONS

Cooperative Occupational Preparation Of The Handicapped: Exemplary Models

Gerard J. Bensberg, Ph.D., And Sylvia Ashby

A joint task force from the Office of Special Education (the Rehabilitation Services Administration; the National Institute of Handicapped Research; Bureau of Adult Education/Division of Vocational and Technical Education; and several state directors of special education, vocational education, and vocational rehabilitation) met during 1977-79 to determine ways to foster better communication and cooperation. It examined the changing and expanded responsibilities of the public school systems for serving handicapped people under the Education of All Handicapped Children's Act, Section 504 of the Rehabilitation Act of 1973, the Vocational Education Amendments, and various pieces of state legislation.

While the above changes were taking place (expanding the school's responsibility), the Rehabilitation Act of 1973 required that state rehabilitation agencies use "similar benefits" available under other programs. In addition, previous studies by the U.S. Government Accounting Office indicated that some states have misused federal rehabilitation moneys through the use of third-party agreements. This practice has led to severe restrictions being placed on third-party agreements and has created considerable strain on cooperative school-rehabilitation programs.

The present study^{1,2} was recommended by members of the interagency task force. Its members believed

that descriptions of exemplary programs that highlight interagency cooperation could stimulate others to do likewise.

An advisory committee, selected from federal and state administrators of special education, vocational education, and vocational rehabilitation, assisted in developing a study plan and in the final selection of exemplary programs. Each state director of vocational education, special education, and vocational rehabilitation was sent a description of the study; the directors were then asked to nominate up to three high quality programs that demonstrated good cooperation among vocational education, vocational rehabilitation, and special education. Selection of the 10 programs for indepth study was based on a program description form. A total of 136 programs were nominated, of which 95 programs desired to participate in the study.

This number was reduced to 22 by eliminating those which did not seem to have serious involvement of all three components or did not serve a variety of handicapping conditions. The advisory committee then ranked the programs, keeping in mind that the project sought a mix of rural and urban programs and representation from various localities. No claim is made that the selected programs are the 10 best in the country because of the difficulty in considering all possible programs in the country and in judging quality on the basis of program descriptions. However, based

upon staff and consultant site visits, the programs are innovative and of excellent quality.

Findings From Nomination Forms

Perhaps the major finding from the exemplary models study is that any community can develop a comprehensive vocational preparation and job placement program for handicapped people. Representation came from throughout the country. They range from population areas of rural 13 thousand to an urban area of 1 million. The school population ranged from 1,085 to 163,052, with half of the programs having 20,000 or more students.

There are more males than females served by the vocationally oriented programs. This suggests a strong sex bias in the selection of students for preparation for employment. Some 55 percent of the handicapped students served were in the mild to moderate range of mental retardation. The learning disabled comprised the next most frequent group, and represented only 13 percent of those served.

Most of the nominated programs take students in the 14-16 age range and continue to serve them until age 21. However, six programs serve children age 6 or younger. A surprising number serve adults, 6 serving those over age 40. Most of the programs operate on a 12-month basis. However, the summer curriculum is usually quite different from the regular school year program.

The major unserved population is the severely handicapped. Almost one-third of the programs which completed the program description form indicated that they could not serve the severely or profoundly mentally retarded. This deficiency tended to apply other groups as well; 26 programs indicated that they could not serve the severely/profoundly hearing impaired. Only 11 percent of the students served represented the severely/profoundly handicapped who are not mentally retarded, hearing impaired, or speech impaired.

The nominated programs varied widely in size and budget. The smallest was supported by only \$10 thousand and the most comprehensive by \$4.3 million. Budget evaluation is difficult because some schools include all funds spent on the total special education program rather than just the cooperative program. However, for programs reporting, the federal share averaged \$132,353; state share \$236,116; the local share, \$127,757. Major federal programs supporting the programs included vocational rehabilitation, Title I of the Elementary and Secondary Education Act, Titles XIX and XX (of Social Security), Vocational Education, CETA, and federal special education funds.

Exemplary Program Results

The 10 programs were twice visited for 2 to 3 days each visit. The first visit was made by two staff members for an overall view of the organization, sources of financial support, and major program components. The second visit was made by outside consultants with expertise in vocational education, special education, and vocational education, along with one or more project staff. The consultants, as well as the administrators of the programs visited, were told that we were focused upon how

they cooperated and why they felt cooperation was good. We did solicit their own self evaluation as to what aspects of their program they felt were outstanding or represented success and which were weaker or had failed in meeting their objectives.

The cooperative programs selected for indepth study were: Bakersfield, California; Cleveland, Ohio; Kent Intermediate (Grand Rapids, Michigan); Houma, Louisiana; LaGrange, Illinois; Manchester, Connecticut; Salt Lake City, Utah; St. Paul, Minnesota; Town and Country, Missouri (St. Louis County); and York, South Carolina.

The complete study report consists of 400 pages and is available at cost from the Research and Training Center in Mental Retardation at Texas Tech.³ It reviews legislation related to the three programs of vocational education, special education, and vocational rehabilitation and reviews the literature concerning interagency linkages, curriculum development in career education, and the role of vocational evaluation as a foundation for curriculum development. Its major sections detail the 95 completed program description forms and describe each of the 10 exemplary programs.

The essential common element in the 10 programs is a dynamic leader who is convinced that social and vocational competence take precedence over all educational objectives. This results in a reordering of older priorities, such as reading or math achievement at the secondary level. This dynamic leader, often the local director of special education, is able to convince the school superintendent and other key administrators of the program's vital importance.

Generally, the larger the school system, the larger the budget. Again, in most cases, creative leadership de-

termined the extensiveness of the vocationally oriented program. In the smaller school systems, the 10 percent set-aside vocational education funds tended to be allocated directly to the special education program in order to enhance the vocational component. In the larger systems, funds were generally controlled by the vocational education department; they were spent for additional adapted vocational education classes or for vocational education teachers who might be assigned to work with special education classes. Generally, vocational rehabilitation funds were used to meet the needs which could not be met with school funds, such as physical restoration (surgery or prosthetic devices), vocational evaluation, vocational counseling, assistance with transportation, and job placement.

When the program administrators were asked, "How do you start such a program?" the consensus was, "You start where you are." Most agreed that special funds and facilities for the vocational preparation program were helpful but not essential. One special education director, for example, suggested that if there were only two teachers at the secondary level, the program could begin. The class could be combined under one teacher for a period permitting the other teacher's time for business and industry contact in the community. For example, a local service club might contribute funds for gasoline and insurance and a car dealer the loan of a van. Even with such a modest beginning, the merits of the program could be easily sold to the school system and to the community; this would soon generate additional funds and staff.

Several administrators advised the early appointing of a committee to recommend curricula, training, and 19

coordination with other units of the school and the community. Through sound deliberations and planning, the committee helps "sell" the program to the school administration.

A characteristic of the exemplary programs is their emphasis on a competency-based curriculum. Most have developed detailed listings of the skills and knowledge required for a particular job. Student progress is measured through tests and demonstrations of their efforts. Some schools divide complex jobs into levels; students must demonstrate competency in a lower level before advancing.

Another characteristic is the emphasis on learning by doing. Most lectures and abstract discussions are supplanted by practical experience. If a particular vocational area requires considerable pretraining before job placement, a simulation is established on the school campus. Several schools have access to the commercial kitchen and school lunch cafeteria. If one of the vocational areas is janitorial, the school purchases (or receives donations or loans from commercial firms) of cleaning equipment.

As soon as possible, students are placed in community jobs. Program philosophy holds that employment is the ultimate measure of success, since there is no substitute for work in a natural setting. As much as possible, employers are encouraged to set the same performance standards for the students as for regular employees. Teachers believe students who work short hours, take long breaks, and do not maintain satisfactory production rates, develop a false notion of work requirements and of their own potential.

Regarding on-the-job training, some variation exists. When the job is complex and the student severely

schools send a staff person along during the orientation and adjustment period. In other settings, employers agree to assign a regular employee to supervise and teach the job tasks and job-related behaviors (such as taking breaks, smoking on the job, etc.) until the student is able to function independently.

Several programs use the supervisor to evaluate student performance. In some instances, the supervisor even assigns a grade. In keeping with this practical experience orientation, one program uses a local employment agency to interview and grade students on their interviewing-for-employment skills.

Difficult to assess is the effectiveness of mainstream versus self-contained programing. Most of the exemplary programs still do not mainstream the majority of their mentally retarded students into regular vocational education classes. They are more successful at mainstreaming the physically handicapped. When the mildly mentally retarded and learning disabled are mainstreamed into regular vocational education classes, it is typically into those courses which make fewer cognitive demands (such as horticulture, building maintenance, automotive maintenance and repair, and child care). Many vocational educators seem to operate under the assumption that there is a specific set of skills which must be learned in a particular class and there is no room for altering curriculum or class outcomes to accommodate those students who cannot accomplish these objectives.

Personnel Preparation

All school members share responsibility for initiating and operating a vocationally oriented program. Many teachers, unfortunately, operate on a subject matter orientation, still believing that math or reading skill is

the most important goal of education. They often resist teaching daily living skills, personal skills, or job-related skills. Therefore, regular teachers should be included in the planning and should participate in inservice training which would help them accept this new orientation.

Of interest: in several of the programs some teachers are certified in more than one area. Some are certified both as vocational educators and as special educators, while some senior staff are certified both as vocational rehabilitation counselors and as special educators.

A number of schools have specialized personnel who play a pivotal role between the school and community. Kent intermediate, for example, employs habilitation counselors to bridge the gap between high school student and post-high school training and/or employment. The habilitation counselor acts as an advocate for students, aiding with the high school IEP and the individualized written rehabilitation program.

Several of the exemplary programs stress the need for early involvement and training of the staff conducting the specialized program. It has been suggested that most schools could apply for a short-term training grant through state education agency in order to hire teachers during the summer prior to the initiation of the program. These teachers could then make a community survey of jobs and devise a curriculum to train handicapped students for these jobs.

Community Involvement

All of the programs have good-to-excellent relationships with the community. There are many community agencies which regularly interact with the schools. They include the local mental health program (typically a part of the state mental health agen-

cy), various public and private rehabilitation facilities (such as Easter Seals or Goodwill), and service agencies such as CETA or child welfare.

In certain cases, of course, educators are preparing students for certification or for state examinations and, therefore, are forced to take that stance. However, little effort seems to be taking place in job restructuring or other approaches that might make a handicapped student employable. One program makes good use of pairing a retarded student with a low-normal or slow learning student so that the more able student assists in teaching the required skills.

Several administrators argue forcefully that it is not possible to provide adequate vocational preparation of the mentally retarded in a mainstream setting. They represent school systems with self-contained high schools or special vocational centers. In these situations, students spend part of the day in their own high school (typically in mainstreamed classes) and come to the special center for part of the day. Administrators here maintain that it is not possible to adapt curriculum, develop special equipment and environments, and provide appropriate teaching staff except in a self-contained, specialized setting. However, these schools do allocate more of their resources for providing vocational preparation of handicapped students than those schools which mainstream most of their students. The success rate of these special schools, in placing and maintaining handicapped students in competitive employment, effectively supports their position.

As the size of the school increases, the size of the special program becomes larger and more comprehensive. Size also tends to correlate with the location of the school district,

whether in a primarily rural or primarily urban area. There are fewer components in the programs and fewer opportunities for job placements in rural or smaller school systems; this results in a wider range of students being served in a particular facility or class. For example, a work activity center which provides prevocational training might serve the trainable and mildly retarded. Innovative instructors are able to make the most of the situation by giving the brighter students the more difficult tasks and then moving them into on-the-job training more quickly.

Perhaps the most exciting relationships are those with the private sector of the community. Most programs have an advisory committee which includes community leaders representing business and industry. The schools report that prominent people are often willing to serve on such committees, as these people perceive the relationship between the quality of the high school curriculum and the quality of employees who graduate from these programs. They can be counted on to help create a bridge between school and community. They not only commit their own firms to the program but can also convince associates to provide job training.

Civic organizations can be of great help to vocationally oriented programs. Their membership usually includes a large number of civic minded community leaders. Hence, the persuasive educational presentations related to accepting and employing the handicapped carries over into their businesses. Equally important is the financial contribution groups can make. There are always areas which are difficult to finance with federal or school funds. Frequently, for example, there is a need for money for paying students who work on campus for precommunity placement. Often a

service club is willing to underwrite this cost by sponsoring some type of fund-raising activity.

Interagency Cooperation

This project sought to identify settings in which the three major component areas concerned with vocational preparation and job placement operate in a cooperative and coordinated manner. We hoped that by studying these programs, we could identify those elements or situations conducive to cooperation. Unfortunately, the complexity of these social institutions made such an interpretation difficult. The 10 programs, which were all visited, do demonstrate a high degree of cooperation and communication. Some are small, others large; some are rural, others urban; some are well funded; others operate on a "shoestring." Hence, in a variety of situations, special education, vocational education, and vocational rehabilitation can cooperate; each can contribute significantly to a successful program.

There are several subjective conclusions drawn by members of the site teams. In every cooperative program there are at least one or two administrators who are persuasive and dynamic leaders. They are able to win the support of other administrators and engender enthusiasm between their staff and the staff of other administrative units. They are convinced that social and vocational competence in handicapped people is more important than achievement in traditional school subjects such as math or history. This attitude tends to make their program community oriented with job placement and independence as ultimate goals.

Differences exist in management style between the small and larger program. In the smaller programs, with limited staff in vocational educa-

tion, special education, and vocational rehabilitation, the cooperation exists on a more personal basis. The administrators realize that they are dealing with the same students; therefore, if help is extended to students by all three programs, then the burden of each individual area is reduced. Recognizing their own limited resources, they may be more aware of their dependence upon one another. As these programs are based in small communities where social interaction is more frequent, perhaps they exert extra effort to be cooperative and helpful. In the larger programs, the administration tends to be handled in a more authoritative manner. Lines of authority are more firmly established; orders to cooperate come out of meetings with the administrators of the three component areas.

In all of these programs, regardless of size, there are staff members in all three component areas who operate at a fairly high degree of independence, laboring at the community level to "make the program work." These people generally are responsible for developing job-training and job-placement, for supervising students, and for the followup which helps students maintain their employment. Administrators recognize the wide variety of problems faced by these staff members and realize that skills in human relations play a major role in their creativity and success. Hence, administrators give them freedom in organizing and carrying out their work, using the yardstick of successful job placement as a determinant of staff success.

Although a study of state level cooperation was not done, it appears that cooperation at the local is vital. This may be partly due to the fact that two components (special education and vocational education) are locally

Though the state agency sets general policies and standards, the local school accepts or rejects some of these policies to a great extent, and decides upon the nature of its own school program. On the other hand, the state vocational rehabilitation agency is administered at the state level; staff in local offices are responsible to the central state office for administration and policies. Clearly, if the state director of vocational rehabilitation ordered that no client services money be spent on handicapped students enrolled in high school, a local counselor would find ignoring such an order difficult.

Several of the exemplary programs have a vocational rehabilitation counselor assigned to one or more high schools and has his office in a high school. In that setting, counselors feel more loyal to the high school students; public school staffs are more accepting of the counselors and are more likely to use their services. If counselors work out of the district office, with a mixed case load, their obligation to school clients is apt to be far less.

As noted before, several of the key staff members in the 10 exemplary programs were trained or certified in more than one area. Several are certified both as special educators and as vocational rehabilitation counselors. Apparently these people are better accepted by the three component areas; this too would facilitate cooperation.

In the analysis of the 95 nominated programs which returned the program description form, vocational rehabilitation is the most frequently mentioned agency with which schools cooperate. Seventy-three indicated they have a working relationship with vocational rehabilitation. The most common type of support (to 30 or more programs) is the provision of psychological/medical/counseling

services, and the provision of job research, training, and placement services.

Among the 10 exemplary programs, three have had third-party agreements and are now undergoing some stress in continuing the program. In one case, the education agency is planning to shift funds to be used for matching purposes, to the rehabilitation agency. In the other two cases, the rehabilitation agency has assumed responsibility for its part of the cooperative program as providers of direct supervision of counselors assigned to the schools. However, the counselors are still located at the schools and the program seems to be continuing in an exemplary manner. One of these programs reports that the average cost for successfully closing a client from the high school cooperative programs is two-thirds less than the cost for a typical adult client. If these statistics apply to other states as well, we may be missing a good opportunity by not strengthening these programs.

Cooperative programs between the public schools and the state vocational rehabilitation agencies vary widely from state to state. In spite of recent changes in legislation, there are many ways in which the two agencies need to work together. The percentage of handicapped people who drop out of high school is still very high. A jointly sponsored program for these youth is more likely to be effective than either agency attacking the problem separately. The rehabilitation agency can be of great help in providing restorative services, vocational evaluation and counseling, and job placement.

Dr. Bensberg is Director of the Research and Training Center in Mental

(Continued on page 27.)

Potpourri Of Deaf-Related Journals

Nidia Moreno Milne, Ph.D.

In attempting to have manuscripts published, beginning writers are faced with a difficult task. After preparing a manuscript, the author's preference is usually to have this paper published in the national journal of his profession. Thus, his first inclination is to submit it to that particular journal. Though, there is nothing wrong in desiring such publication, the inexperienced writer must remember that hundreds of other beginning as well as experienced, already published writers are also submitting papers to these journals.

If the novice is lucky and has his paper accepted, his problem of publishing it is over. But it is not likely that his manuscript will be accepted the first time around. Thus, he is left with a rejected article, and he begins to wonder what he did wrong. Initially he asks, "Where do I submit my paper now?" And, since the first journal rejected his paper, he would like to be sure of the criteria for publication required by the next journal.

While the criteria required by a profession's major journals are usually well-known, those of other rotated journals are not so familiar. Thus, when submitting a paper to these journals, writers asks questions such as: "Should I send two or three copies?" "How long should it be?" and so on. With these questions in mind, a survey of deaf-related journals was conducted during the Spring 1978.¹ Each listing provides a brief description of the journal's content and editorial policy, the address for manuscript submission, and the price (when available) of a single copy. In this article, 37 journals are grouped into four categories: educational, technical/medical, vocational type, and general education and parent journals.

Each journal editor responded to a questionnaire, giving both general and specific information about the journal's criteria. This information is presented in the annotations that accompany the journals listed. The first three items in each listing are the journal title, the sponsoring organization, and the name and address of the editor. The general information includes such items as number of issues per year, length of journal, and circulation. The specific information includes such items as themes for future issues, areas of greatest interest to that journal's readers, and advice from the editor. Each journal is listed in one or more of these sources: *Literary Marketplace*;² *Directory of Publishing Opportunities*;³ *Exceptional Child Ed-*

ucation Abstracts;⁴ and *Ulrich's International Periodical Directory*.⁵

Educational Journals

This section is so broad that only a small sampling of such publications could be included. In addition to the journals listed, the regional and state journals are another good source for article placement.

Children Today

Sponsoring Organization: Children's Bureau, HHS

Editor: Judith Reed, Box 1182 Children's Bureau, Washington, D. C. 20013.

Six issues are published yearly by this international journal. It has a circulation of approximately 24,000. Manuscripts between 4-7 pages submitted in duplicate are preferred. Price for a single copy is \$6.10.

The ACEHI Journal/La Revue Aceda

Sponsoring Organization: Association of Canadian Education of the Hearing Impaired

Editor: Russell Fisher, 29 Cedar Street, Belleville, Ontario, Canada.

Deafness and multiply handicapped topics are most frequently published by this quarterly journal. Manuscripts between 4-7 pages or 9-12 pages are preferred.

Language And Speech

Sponsoring Organization: Kingston Press Services, Ltd.

Editor: Prof. A. S. Abramson, 1796 High St., Hampton Hill, Middlesex, England.

This international journal is published on a quarterly basis and distributed to 1,200 educators. There are 100 pages per issue. A single copy is \$12.

British Journal Of Educational Psychology

Sponsoring Organization: British Psychological Society.

Editor: Professor N. J. Entwistle, J. B. Nisbet, Scottish Academic Press, Ltd., 25 Perth St., Edinburgh EH 35 DW, Scotland.

The three yearly issues of this 70-page, international journal are circulated to 3,500 educators. Two copies, between 4-7 pages or 12-16 pages, are preferred.

Journal Of Educational Psychology

Sponsoring Organization: American Psychological Association.

Editor: Joanna Williams, 1200 17th Street, N.W., Washington, D.C. 20036.

This international journal focuses on applied research and theory. Three copies, between 20–24 pages, are preferred. A single copy is \$6.

Journal Of Educational Research

Sponsoring Organization: Heldref Publications.

Editor: Louise M. Dudley, Helen Dwight Reid Educational Foundation, 4000 Albemarle St. N.W., Washington, D.C. 20016.

This international journal also focuses on research and applied research. Charts and figures can be included. Published six times a year, it has a circulation of 5,000. Price for a single copy is \$3.

The Reading Teacher

Sponsoring Organization: International Reading Teacher.

Editor: Janet B. Binkley, 800 Barksdale Road, P.O. Box 8139, Newark, Delaware 19711.

The eight yearly issues of this 128-page international journal are circulated to 56,000. Articles for this educational journal should emphasize reading and language arts. Three copies, between 9–12 pages, are preferred. Price for single copy is \$2.

Special Education: Forward Trends

Sponsoring Organization: National Council for Special Education.

Editor: Margaret Peter, 17 Pembridge Square, Longon W. 24 E.P., England.

Manuscripts relating to both verbally and/or physically handicapped with learning difficulties are welcomed. Published four times a year, this international journal has a circulation of 6,800. Photographs and/or illustrations can be included in this 44-page journal.

Journal For Special Educators

Sponsoring Organization: American Association of Special Educators.

Editor: Dr. Alfred Lazar, Dept. of Educational Psychology, California State University, Long Beach, Calif. 90840.

This international journal, with a circulation of 2,000, is published three times a year. Two copies of the manuscript between four and seven pages are preferred. It con-

siders topics on all areas of exceptionality. Price for a single copy is \$3.50.

Technical Journals

Journal Of The Kansas Speech And Hearing Association

Sponsoring Organization: Kansas Speech and Hearing Association

Editor: Robert L. McCroskey, Ph.D., Wichita State University, Dept. of Logopedics, Wichita, Kansas 67208.

Published three times a year, this 40-page journal considers speech pathology and audiology topics. Photographs or illustrations are accepted. Price for a single copy is \$4.

Hearing Aid Journal

Editor: Donald V. Radcliffe, Milton/Bolstein, 305 Benson Bldg., Sioux City, Iowa 51101.

Illustrations or photographs can accompany manuscripts for this 48-page international journal. With a circulation of over 9,000, it considers topics on hearing aids and related subjects; research on the hearing impaired; and instrumentation and developments concerning hearing health. A single copy is \$1.50

Journal Of Speech And Hearing Disorders

Sponsoring Organization: American Speech and Hearing Association.

Editor: Dr. William H. Perkins, 9030 Old Georgetown Rd., Washington, D.C. 20014.

Over 40,000 readers receive this journal four times a year. Topics most frequently published relate to specific disorders with focus on clinical application. There is no minimum or maximum number of pages preferred, but 5 copies are requested. Manuscripts must report reliable information of clinical relevancy. A single copy is \$9.75.

Journal Of Speech And Hearing Research

Sponsoring Organization: American Speech and Hearing Association.

Editor: Thomas J. Hixon, 9030 Old Georgetown Rd., Washington, D.C. 20014

This quarterly national journal has a circulation of 40,000. Figures and tables can be used. Four copies of a manuscript are requested. Research on communicative impairments is highly desirable. Price for a single copy is \$9.

Teacher Of The Deaf

Sponsoring Organization: British Association of Teachers

of the Deaf.

Editor: Mr. D. R. Harrison, National College of Teachers of the Deaf, 32 Merston Drive, East Didsbury, Manchester M. 20 OWT, England.

This international journal published 6 times a year has a circulation of 2,400; 40 pages per issue. Topic most frequently published: education of hearing-impaired children.

The Psychological Record

Sponsoring Organization: Kenyon College.

Editor: Charles E. Rice, Deneson University, Granville, Ohio 43025.

The principal interest of this international journal is basic research in sensory functioning and learning. Two copies of the manuscript, between 4–7 printed pages are preferred.

Scandinavian Audiology

Sponsoring Organization: Scandinavian Audiological Society.

Editor: Stig Arlingen/Bjorn Blegvad, Dept. of Audiology, University Hospital, S 58185 LINKÖPING, Sweden.

The topic most frequently published is audiology: diagnostic methods and rehabilitation. This journal prefers articles of 9–12 pages.

The Volta Review

Sponsoring Organization: Alexander Graham Bell Assoc. for the Deaf.

Editor: Dr. Wilbert L. Pronovost, 3417 Volta Place, N.W., Washington, D.C. 20007.

Themes for future issues include: speech instruction, mainstreaming and the adolescent. Three copies, between 9–12 pages, are preferred. Six issues are published yearly. Price for a single copy is \$2.

Rehabilitation Literature

Sponsoring Organization: National Easter Seal Society for Crippled Children and Adults.

Editor: Helen B. Crane, 2023 West Ogden Ave., Chicago, Ill. 60612.

This international journal has a circulation of 3,000. Two copies are required. Photographs and illustrations can be included. Price for a single copy is \$2.

Medical Journals

Annals Of Otolaryngology And Laryngology

Sponsoring Organization: American Otological Society, American Broncho-Esophagological Ass'n, American

Laryngological Ass'n.

Editor: Ben H. Senturia, M.D., 4949 Forest Park, St. Louis, Missouri 63108.

The six yearly issues of this 160-page international journal are circulated to 5,225 professionals. Articles should emphasize clinical and medical research. Three copies, between 12–16 pages, are preferred. Price for single copy is \$10.

Journal Of Auditory Research

Sponsoring Organization: The CW Shilling Auditory Research Center, Inc.

Editor: J. D. Harris, C. W. Shilling Auditory Research Center, Inc., Box N, Groton, Connecticut 06340.

The quarterly has a circulation of 1,300. Hearing science is most frequently published. Recommendation for prospective contributors is: any serious rigorous study of human or animal hearing. A single copy is \$3.

British Journal Of Disorders Of Communication

Sponsoring Organization: College of Speech Communication Therapists.

Editor: Betty Byers Brown, Longman Group, Ltd., 43/45 Annandale St., Edinburgh E. H. 74 A. T. Scotland.

Speech and language pathology are most frequently published in this biannual, international, 80-page journal. Two copies are preferred. Photographs and illustrations are welcomed.

Sound And Vibration

Sponsoring Organization: none.

Editor: Jack K. Mowry, Acoustical Publications, Inc., 27101 East Oveatt Road, Bay Village, Ohio 44140.

Published 12 times a year, this journal invites contributions on topics of noise and vibration control and hearing conservation. Photographs or illustrations may be included with manuscripts submitted to this 40-page journal.

Journal Of Abnormal Psychology

Sponsoring Organization: American Psychological Association.

Editor: Leonard D. Eron, American Psychological Association, 1200 17th Street, N.W., Washington, D.C. 20036.

Research, applied research, and applied theory are types of articles most frequently published in this 110-page journal. Published six times a year, it has a circulation of over 6,000. A single copy is \$6.

British Journal Of Audiology

Sponsoring Organization: Royal National Institute for the Deaf.

Editor: Dr. J. D. Hood, Royal Nat'l. Institute for the Deaf, Co-Sponsor British Society of Audiology, 105 Gower St., London W.C.I.E. 6 A. H., England

With 30 pages per issue, this international quarterly has a circulation of 1,700. It invites contributions, preferably 4-7 pages, on topics relating to audiology. A single copy is \$4.

Vocational Journals

American Rehabilitation

Sponsoring Organization: Rehabilitation Services Administration, Department of Education.

Editor: Ron Bourgea, Dept. of Ed., Room 3525 MES, 330 C St. S.W., Washington, D.C. 20202.

The six yearly issues of this 32-page, international journal has a circulation of 8 to 9,000. The editor prefers 9-12 page articles dealing with any phase of rehabilitation. A sample copy is free. Specifications sheet available, upon request.

Language, Speech And Hearing Services In The Schools

Sponsoring Organization: American Speech and Hearing Association.

Editor: Dr. Gerald G. Freeman, 9030 Old Georgetown Road, Washington, D.C. 20014.

This national quarterly distributes 12,000 copies per issue. Articles most frequently published are in the area of communicatively-impaired children. A single copy is \$3.60.

Journal Of Rehabilitation Of The Deaf

Sponsoring Organization: American Deafness and Rehabilitation Association.

Editor: Dr. Glenn T. Lloyds, 814 Thayer Ave., Silver Springs, Maryland 20910.

This 32-page, international quarterly has a circulation of 1,500. The types of articles most frequently published relating to deafness are: book review, parent needs, applied research, materials, rehabilitation, and methods. A single copy is \$4.

Horgeschadigtenpadagogik

Sponsoring Organization: none.

Editor: Bund Deutscher Taubstummenlehrer, Juluis Groos Verlag, Box 102423 D-6900, Heidelberg, W. Germany.

This 64-page, international journal, published six times a year, addresses the theoretical and practical contributions on the pedagogy of the deaf and related fields. The

editor prefers 2 copies, between 1-4 pages.

Hearing Instruments

Sponsoring Organization: Harcourt Brace Jovanovich.

Editor: Marjorie Skafte, One East First St., Duluth, Minn. 55802.

This international magazine has a circulation of approximately 14,000. The editor prefers one copy of the manuscript, between 9-12 pages long. The topic most frequently published is in hearing aids and hearing-testing. It is concerned with hearing impaired people and prevention of hearing loss. A single copy is \$2.

General Information and Parent Journals

Hearing And Speech Action

Sponsoring Organization: National Association for Hearing and Speech Action.

Editor: Harold Schwartz, 814 Thayer St., Silver Springs, Maryland 20910.

This 20-page, international journal publishes general interest articles dealing with the hearing and speech impaired and the deaf. Two copies, between 4-7 pages long, are preferred. A sample copy is \$1.25.

Hearing

Sponsoring Organization: The Royal National Institute for the Deaf.

Editor: Antony Burton Brown, Royal Nat'l Institute for the Deaf, 105 Gower St., London W.C.I.E. 6 A.H., England.

The six issues of this international journal focuses on book reviews, applied research, applied theory, materials (aids), rehabilitation, general information, and also "fillers" are always welcome, providing they are not too USA oriented. A sample copy is 25 pence.

Demana

Sponsoring Organization: Association of Deaf in Israel.

Editor: Sylvia Parry, Asso. of the Deaf and Mute in Israel, Helen Keller Home, P.O. Box 9001, Tel-Aviv, Israel.

Future themes for this international journal published quarterly include education in vocational training. Three copies, between 1-4 pages or 4-7 pages, are preferred. Sample copy is free.

British Deaf News

Sponsoring Organization: The British Deaf Association.

Editor: Dr. Greenaway, A. B. Hayhurst MBE, J. F. Hudson, 38 Victoria Place, Carlisle, England.

Topics accepted are on deafness. Other articles by deaf people on any subject are most frequently published. Publications are copyrighted. Photographs or illustrations are used. A sample copy is 10 pence, plus postage.

Talk

Sponsoring Organization: National Deaf Children's Society.

Editor: Mrs. F. Bloom, O.B.E., 31 Gloucester Place, London W1, England.

Four issues are published quarterly with welfare topics most frequently published. Two copies between 1-4 pages are preferred.

Silent Messenger

Sponsoring Organization: S.A. National Council for the Deaf.

Editor: The Director, S.A. National Council for the Deaf, Box 30663, Broomfontein T.V.L., South Africa.

This 16 page, international quarterly issue has a circulation of over 2,000. Education and social work services topics are most frequently published. Two copies, between 1-4 pages, are requested.

Hearing Rehabilitation Quarterly

Sponsoring Organization: New York League for the Hard

of Hearing.

Editor: Joan B. Martin, 71 West 23rd Street, New York, N.Y. 10010.

Rehabilitation of hearing impaired—psychological, educational, and social—is the topic most frequently published. This journal includes: book reviews, research, and classroom applications. The price for a single copy is \$1.25.

Dr. Milne is Assistant Professor, Special Education Program Area, University of Houston.

References

- 1) Moreno-Milne, N. "Publishing Policies of Deaf-Related Journals." (Questionnaire survey results available from author through College of Education, University of Houston) 1978.
- 2) *Literary Marketplace*. New York, N.Y.: R.R. Bowker Company, 1976.
- 3) *Directory of Publishing Opportunities*. Chicago, Illinois: Marquis Who's Who Books, 1976.
- 4) *Exceptional Child Education Abstracts Summer 1976*. Reston, Virginia: The Council for Exceptional Children, 1976.
- 5) *Ulrich's International Periodical Directory*. New York, N.Y.: R. R. Bowker Company, 1976.

ECONOMIC BENEFITS

(Continued from page 6.)

habilitations, and increasing proportions of severely disabled people for whom remunerative outcomes are less likely.

Benefits To Government

In the first year after closure, people rehabilitated in fiscal year 1979 are expected to pay an estimated \$88.8 million more in social security payroll taxes than they would have paid without the intervention of rehabilitation services. In addition, an increase of federal income tax payments of \$99.3 million is projected for the first year, as are \$14.2 million in state and local income taxes and \$28.5 million in state and local sales tax receipts. Further, a decrease in dependency on public assistance of \$39.8 million will be effected in the first year after rehabilitation. These

tax returns and savings add to \$270.6 million for the first year.

Since the estimated total cost of services for all cases closed in fiscal year 1979 was \$1,072 million, it will take only 4 years for the investment in rehabilitation to be totally paid off at current tax rates, or 5 years if inflationary trends are factored in and no changes in tax rates are assumed.

COOPERATION

(Continued from page 22.)

Retardation at Texas Tech University. He is a professor in the Departments of Special Education and Psychology. Mrs. Ashby is a writer and also a Research Associate with the Research and Training Center in Mental Retardation.

Notes And References

- 1) This study was supported, in part, by the National Institute on Handicapped Research, U.S. Department of Education, Grant #16-P-56819/6.
- 2) This project used a number of staff plus outside consultants who assisted with site visits to the exemplary programs. The authors would particularly like to express their appreciation to Dr. Bill Barley and Jerry Bean who assisted in writing the program descriptions and Dr. Elinor Gollay and Lucy Collier who conducted an analysis of the nominated programs.
- 3) Ashby, Sylvia, and Bensberg, Gerard J. (Eds). *Cooperative Occupational Preparation of the Handicapped: Exemplary Models, 1981*. Available from the Research and Training Center in Mental Retardation, Box 4510, Texas Tech University, Lubbock, Texas 79409.

Community Based Attendant Care: A Key To Independent Living

Homer Page, Ph.D.

The following paper presents a model for training personal aides. Obviously, there are other approaches, *e.g.*, since the turn-over rate for attendants is high, some people believe that the person needing the service of an aide should receive training in Aide Management so that the disabled person becomes the aide's teacher as well as his supervisor.

Up front, there also may be a need for better screening of potential aides to obviate the disparity between the handicapped person's needs, on the one hand, and both his and his attendant's expectations of the job, on the other hand. There may be many other variations worthy of emulation, as well. **Editor**

Until now, most severely, physically disabled people have not been able to live independent lives because of a dependence on nursing homes or relatives for basic, personal care. However, during the last decade, recognition of this waste of human life has been acknowledged with growing forthrightness. The forming of community based, independent living centers that provide services and act as institutional footholds, from which people with disabilities advocate for needed programs, have begun to at-

tack the need for personal care assistance.

Some changes in income maintenance and state and federal medical programs are beginning to make personal care in living economically possible. But all the pieces in the personal care assistance puzzle are just beginning to fall into place. For this reason, the Center for People with Disabilities in Boulder, Colorado, has developed a management training program to assist new personal care programs.

The training program takes 3½ days. It has been offered through the Regional Rehabilitation Continuing Education Program, Social Service, and The Center for Independent Living personnel in U. S. Department of Education Region Eight.

The following discussion sets forth the training elements, its goals, and an analysis of some dangers to the independence of disabled people which an organized personal care program may present.

I

Boulder County is located some 30 miles northwest of Denver. It covers over 700 square miles of high plains and Rocky Mountains. There are two population centers, Boulder and Longmont. Together they make-up

about 65 percent of the population. The Boulder County Center for People with Disabilities (CPWD) provides independent living rehabilitation services to people with disabilities in Boulder County.

CPWD was founded in 1977, and began operation on October 1 of that year. Initial funding came from the Boulder County Division of CETA Programs. Over the years, the funding base expanded. An innovation and expansion grant from the Colorado Division of Vocational Rehabilitation created a job development and placement program. Funding from the city of Boulder and from Boulder County covers administrative costs. A contract with the local CETA program permits job training and job placement. A United Way grant contributed to the development of a transition residential living program which uses apartments (licensed from the Boulder Public Housing Authority) to assist in the transition from family, hospital or nursing home to independent living. The CPWD will become a United Way agency in 1981, and will also receive funding through Independent Living Rehabilitation program established in Title VII of the 1978 Rehabilitation Amendments. Some fees for direct services are assessed to clients, and

contributions from private sources round out its funding.

CPWD provides comprehensive services and involves disabled people at its highest levels of leadership and decisionmaking. Both the chairman of the board of directors and the executive director are blind. Staff and board members serve on numerous local and state boards and commissions. Advocacy on behalf of civil rights and legal entitlements are routine actions taken by members.

Growing success at placing disabled people in employment and in education and training, coupled with the experiences of the transition program, have driven home the need for an organized personal care assistance program, for many people, such a program is the only way to escape a life of dependence and actually to live to their potential. CPWD has responded to this need by establishing such a program.

In August 1980, Mr. Art Zamora of the RSA Region VIII office and Dr. Vincent Scalia of the University of Northern Colorado's Regional Rehabilitation Continuing Education Program (RRCEP) program were approached to secure sponsorship for a training program to be offered by CPWD to rehabilitation personnel in the region. It would formalize the experiences of CPWD in establishing a community based attendant care program. RRCEP agreed to sponsor the training program, and it was offered during the week of December 9, 1980.

The purpose of the training was to acquaint rehabilitation personnel who have responsibility for establishing attendant care programs with the elements of a community based program. Three goals were established: to present a management approach to the establishment and administration of a program; to acquaint participants with the actual services provided by a

personal care assistant, that trainees might better grasp both the importance and the possibilities of such services; and to promote an attitude toward personal care assistance that would be consistent with the development of an independent lifestyle by the person receiving the service.

II

Personal care may well be a key to independent living for many disabled people, but it may also be a threat to this goal. The disabled person is dependent upon the assistance of the attendant for the most basic personal needs; consequently, the delivery of personal care services must minimize dependence while promoting a growing independence. The training program which will be discussed emphasizes the conjunction of personal care services with strategies for developing attitudes and skills by the disabled people.

Because the conjunction of a personal care assistance program with independent living is not always easy to achieve, the author believes that it is appropriate initially to set out the philosophical assumptions on which the CPWD program has been built. Perhaps the most basic issue is why an independent living center should sponsor such a program. Shouldn't disabled people simply find their own attendants with, at most, a list of people looking for such work provided by the center?

There are three categories of people who need attendant care. First there are those who are fully in control of their life. They have the financial and personal resources to manage their own personal care. They do not need assistance except, perhaps, for an occasional referral about a person seeking employment as a personal care aide. Achieving this level of independence is the ideal; however, not

every person is capable of it.

A second category is those who wish to achieve a higher level of independence than they currently possess, but lack either financial resources or personal skills necessary to achieve it. These are people for whom we are most concerned and for whom our program was designed.

The third category either cannot or do not wish to live independently. They may be elderly, lacking in mental capacity, or simply the victims of too much custodial treatment over too many years. In any case, we have chosen not to work with them except in emergency situations.

How we determine a person's category is crucial to the development of a conjunction between independent living and the delivery of personal care services. The determination is based on his goals for independence and the degree to which the services are desired. We develop a growth plan with the client which determines the services to be provided. If the person decides that such a growth plan is not to his liking, then he is, of course, free to live as he chooses. Our services are contingent on developing a growth plan which is directed toward developing greater independence in disabled people.

Defining what independent living involves is no small task. Two elements are key factors in transforming a life of dependence into one of relative independence. First the disabled person must be able to control the relationships in which he finds himself and he must have more lofty goals (a purpose) in life for which personal care is but a tool. The growth plan developed jointly by person and center aims toward achieving these goals.

Controlling one's personal care is the essential first step toward independence. The disabled person needs to recruit, interview, and hire aides; 29

instruct their performance; arrange payment; and terminate them for unsatisfactory service. This requires knowledge, assertiveness, and financial resources. The aide is a resource for a disabled person, and learning to control and manage that resource is a necessary step toward full independence.

It is not enough to get up in the morning, get dressed, and get into one's wheelchair. There must be something then to do. There must be a purpose for which the personal care is but a useful tool. The disabled person may, like anyone else, find that purpose in family responsibilities, social or recreational activities, education or volunteer work, in gainful employment, or in other ways, but a purpose for which one can make a commitment is of the utmost importance.

The conjunction of independent living with attendant care services comes at the point that a disabled person can control that service for larger life purposes. It follows that providing personal care services by a community based center for independent living can be done authentically only as the client also receives the encouragement, training, and counseling in life goal planning which may need to develop an independent living style.

III

The Regional Rehabilitation Continuing Education project, located at the University of Northern Colorado, sponsored the training program. Twenty-two people from Utah, Wyoming, Montana, North and South Dakota, and Colorado attended the training program.

Region VIII is largely rural and thinly populated but very large geographically. Its philosophical beliefs, as well as its geography, points toward the necessity of community

based programming. The author believes, however, that this approach is important to all sections of the country. Personal care assistance programs require careful coordination, comprehensive services, and continual contact with the client. Limited layers of bureaucracy allow flexibility, responsiveness, and dedication on the part of staff that is essential to the operation of a successful program.

Management Tools. The first goal of the training program was to present a set of management tools which could provide trainees with a structure that is essential to a community based program. Four aspects of this structure were presented. They were: The recruitment, hiring, and training of a pool of personal care aides; the identification of clients and the development with them of a structured growth plan; the delivery of personal care services; and the supervision and evaluation of the quality of services and growth of the client toward goals of independence.

Traditional techniques of recruiting aides were discussed. The importance of finding motivated, caring, and dependable people to fill these positions was emphasized. Personal care aides receive relatively low pay, work often at unusual hours, and are called upon to provide a wide range of personal services which require skill and sensitivity; consequently, it is important to monitor carefully applicants for these positions. A model contract was presented which formalizes the responsibilities which the aide must assume as well as the relationship between the aide and the CPWD.

Each aide is required to participate in a structured training program run by CPWD staff, regardless of past experience. This is to acquaint the aide with the scope of the service to be given and to impress upon him the appropriate attitude which is necessary

to assist the client to grow toward independence.

The aide must work cooperatively with the client, recognizing that the client must control the relationship. The aide must also understand the holistic approach involving proper nutrition, health, social and community involvement, and growing purpose which is so important to the goals of independent life.

Client referral, intake interviews, and growth plans were discussed. The emphasis that CPWD places on independent living in discussions with clients was explored. A model plan was presented and the procedure by which the client and CPWD staff develop goal objectives and implement services was thoroughly covered. A contract, which the center uses to formalize the relationship between the client and CPWD, was submitted for discussion.

Methods of supervision were outlined. CPWD supervisory staff visits in the client's home at least once a month to monitor the service being provided by aides. The delivery of personal care assistance must be coordinated to insure dependability. It is necessary that the center coordinating staff be available at all times. Some methods for organizing this were set forth. Throughout the training program, concrete information regarding the nature of P.C.A. was presented.

Evaluation of both the quality of service being offered and the growth of the client is central to the management plan. It is not an afterthought. An evaluation form used to elicit from the client his view of the quality of the service was gone over. Both subjective and objective factors in the evaluation were noted. The regular evaluation with the client of the personal growth plan was noted. At these regular meetings up-dates to the plan

were made. Client success or failure in achieving goals were evaluated and future directions were mapped.

The management structure was supplemented by discussions of resources for funding personal care programs. The multiple funding base of the CPWD was explored. Federal and state sources for paying attendants were listed, and many community resources for developing accessible housing, providing transportation, and securing volunteers for less technical aspects of the program were mentioned. The CPWD's use of community development block grant funds to retrofit a private house for accessibility was especially brought to the attention of the trainees.

This section of the training program was meant to provide trainees with management concepts and materials necessary to develop and operate an attendant program. It sought to present a practical approach to achieving the ideals of growth toward an independent lifestyle for severely, physically disabled people.

Personal Care Services. A second major emphasis of the training program dealt with the work that a personal care aide performs. While management level personnel may never be called upon to perform such tasks, it is crucial that they understand concrete tasks that are done by an aide as well as have an understanding of the scope of an aide's work in promoting independent living. The success with which an aide delivers services will determine the extent to which this service will be a key to independent living. The imagination of the management personnel, coupled with their realistic assessment of the needs of the client, will determine the success of the aide.

A presentation on creating and maintaining a germ free environment began to focus attention on the natu-

ral body functions that are a major part of personal care. A second lecture discussed bowel and bladder management among spinal cord injured people. A speaker from a local hospital outlined methods for dressing, transferring people from bed to wheelchair, brushing teeth, and other aspects of the attendant's tasks. A slide presentation made by the director of the local Visiting Nurses' Program demonstrated the performance of personal care assistance. These presentations, when taken together, sought to drive home the importance of dependable and competent personal care assistance. It is at this level that a disabled person is truly dependent on such care for health and life. Without it, everything else is impossible. Many (perhaps most) people needing attendant care are forced to sacrifice independence in order to have basic support care.

But personal care assistance for independent living does not terminate here. A nutritionist gave trainees information on physiological and psychological reasons why disabled people may follow poor nutritional practices. Connections between diet and health were made. Menus were explored that are both high in nutritional value and more easily prepared by people with disabilities.

A presentation on modifying the home for more independent use drew from CPWD's experience with home teaching. This was linked with a program on architectural barriers and their removal. CPWD has a grant from the Community Development Block Grant to modify private homes and apartments to make them accessible.

Finally, this part of the training was concluded with a visit to CPWD's independent living program, which is a residential transition center. Students enter the program for a

period that ranges from 3 months to a year, averaging 6 months. The student develops skills of daily living; learns to use community transportation; explores social, recreational, and cultural activities; and works on developing career goals, with the hope that each student leaves the program with clear educational or job opportunities. Program staff and students explained the program's operation and gave trainees a tour of the student's apartments.

Positive Attitudes. Most basic to the development of an independent living approach to a personal care program is the distinction between the disabled person as a patient, on the one hand and as a client or student, on the other. In a presentation entitled, *Disease or Disability*, the point was made that the client of a personal care program is not a patient. He is a person with a disability who needs a service, but who is fully capable of controlling his care and life.

A panel of four personal care services users talked with trainees about managing care. Personal and emotional dimensions of the relationship between the disabled person and the personal care aide were explored. The need for a balance between professional relationship and friendship was commented upon. Panel members spoke about the growth that they experienced in learning to manage their personal care. Hiring, firing, setting rates of payment, working out schedules, and training aides with to the needs of each member were management responsibilities that they saw as crucial in personal care.

The workshop concluded with a film made by Barry Carbet, a paraplegic from Colorado. Entitled *The Outsider*, the film explores how spinal cord injured people actually live, work, and feel, by looking into sexuality, employment, family life, recre-

ation, and many other experiences of living. As one of the persons in the film states, "This may not have been the life I would have chosen, but it has been my life, and it has been on the whole a good life."

IV

Each of the 14 trainees evaluated the training. Adequacy of subject matter, quality of presentations, and quality of materials were areas about which comments were solicited. While a few participants would have changed the emphasis in one way or another, the overwhelming opinion was that the approach represented a proper balance among management,

service delivery, and attitudinal concerns.

We would recommend that future training done in this area would balance management, service delivery, and appropriate attitudes in the training plan; focus on the centrality of attendant services; point out the pitfalls connected with providing such services with regard to blocking a person's growth toward independence; provide ample opportunities for trainees to talk at first hand with people using personal care services and to see first hand independent living projects; and wrestle with the meaning of independence for severely disabled people at each step.

As the movement grows, personal care programs will provide a key to the successful achievement of their goals. It is not inexpensive to provide this service, but when compared to options currently available, it becomes both cost effective and humane to push ahead with community based independent living oriented personal care programs. The struggle to make all the pieces fit together will not be an easy one, but the personal and social freedoms of many people are at issue.

Dr. Page is Director, Office of Services To Disabled Students, University of Colorado, Boulder.

REPORT RESOURCES

FOCUS ON RESEARCH: RECREATION FOR DISABLED INDIVIDUALS. Regional Rehabilitation Research Institute on Attitudinal, Legal and Leisure Barriers, George Washington University, 1828 L Street N.W., Suite 704, Washington, D.C. 20036.

AFFIRMATIVE ACTION FOR THE DISABLED: A HOW TO MANUAL FOR LABOR UNIONS. The Regional Rehabilitation Research Institute, Industrial Social Welfare Center, Columbia University School of Social Work, 622 West 113th Street, New York, N.Y. 10025.

INTERNATIONAL JOURNAL OF THERAPEUTIC COMMUNITIES. Volume 1, Number 1. 1980.-Quarterly. Human Sciences Press, 72 Fifth Avenue, New York, N.Y. 10011. \$18. annual subscription. "An interdisciplinary journal which covers the field of therapeutic communities, therapy, and the psychodynamics of

large groups, natural groups, and both small- and large-scale therapeutic institutions."

PSYCHOSOCIAL TREATMENT AND REHABILITATION OF YOUNG ADULT SCHIZOPHRENIC PATIENTS. K. Jankowski, M.D., Synopsis Project, 420 Michigan, Lawrence, Kansas 66044.

OPTIONS FOR INVOLVEMENT, COMMUNITY RESOURCES FOR THE SOCIAL ADJUSTMENT OF SEVERELY DISABLED PERSONS. ICD Rehabilitation and Research Center, 340 East 24th Street, New York, N.Y. 10010. \$6.

PUBLICATIONS AND AUDIO-VISUAL AIDS LIST, 1980-81. National Home Caring Council, Inc., 67 Irving Place, New York, N.Y. 10003.

A COMPARISON OF COMMERCIAL VOCATIONAL EVALU-

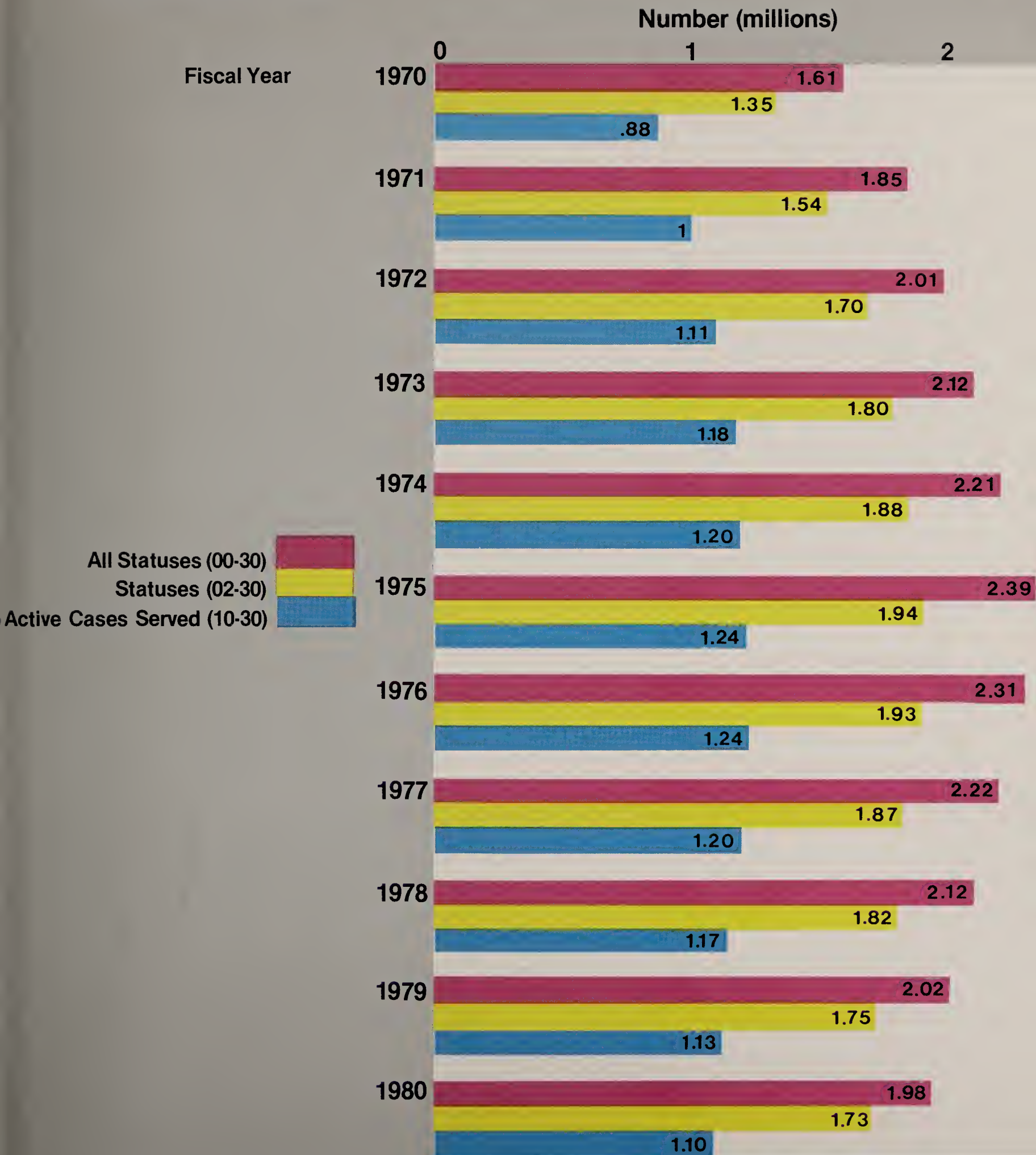
ATION SYSTEMS. Karl F. Botterbusch, Ph.D. Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin-Stout, Menomonie, Wisconsin 54751. 106 pages. \$5.

ANALYSIS OF FY 1977-1978 DATA ON THE VOCATIONAL REHABILITATION STANDARDS. Rehabilitation Services Administration, Office of Program Development, Evaluation and Utilization Bureau, 330 C Street, S.W., Washington, D.C. 20202.

FITNESS IS FREE, BUT YOU HAVE TO WORK FOR IT. G. Timothy Milligan. Arkansas Rehabilitation Research and Training Center, University of Arkansas, Fayetteville, Arkansas 72701.

AN APPROACH FOR THE PHYSICAL THERAPY MANAGEMENT OF THE INDIVIDUAL WITH C6 QUADRIPLEGIA. Priscilla Moe. Department of Physical Therapy, The Institute of Rehabilitation and Research, 1333 Moursund Avenue, Houston, Texas 77030.

Number of Cases Handled/Served, Fiscal Years 1970-1980



There were 1,988,205 cases available in all statuses (00-30) during Fiscal Year 1980. This was the fifth straight annual loss and the first time in 9 years that this measure fell below two million cases. Active cases served and the number of cases available in Statuses 02 through 30 also declined for the 5th year in a row in Fiscal Year 1980 to 1,095,139 and 1,728,987, respectively.

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1981 International Year of
Disabled Persons

NOV.-DEC. 1981

AMERICAN REHABILITATION

Let the message go forth...

Predictions

Jean Tufts
Assistant Secretary Designate
Office of Special Education
And Rehabilitative Services

Office of Special Education
and Rehabilitative Services

The following is excerpted from a speech before the National Rehabilitation Association's (NRA) annual meeting, September 3, in Indianapolis.

Mrs. Tufts predicates her predictions upon the facts of the present, namely, that the Administration feels that more of rehabilitation's burden should be shared by private industry, that the demands for a balanced national budget will make federal dollars more and more scarce, that better management can improve the present service system, that clients should have a greater say in their treatment and training, and that financing can come through many sources additional to the federal avenue.

With these caveats in mind, she unofficially predicted:

- State programs will continue to be funded with federal funds, but will effectively have fewer spending dollars.

- State rehabilitation programs, will, then, begin to find other sources of funding. They will have agree-

ments with education, with the Community Mental Health Centers, and with Public Health Service for example to get needed rehabilitative services to disabled persons. Funds to successful agencies will come from numerous sources.

- Private sources of funding will constitute the major financiers of independent living, rehabilitation facilities training, and other projects with industry. These programs, now funded by RSA, are meant to be catalytic—not static. *When* (not *if*) they work, they will show industry where to invest for the highest payoff—in disabled persons.

- Professional organizations, such as NRA, and others like National Association of Rehabilitation Facilities, the Council of State Administrators of Vocational Rehabilitation, and the National Council on Rehabilitation Education, will be meeting regularly with me in order to give us valuable insight and guidance in plans for the future of OSERS monies and programs.

- RSA will work cooperatively with other OSERS agencies for the development of a continuum of services for chronically handicapped children and youth, while still retaining their special identity for services to the disabled adult. Plans, theory, research and models will be jointly funded to effect the development of a special education/rehabilitation continuum.

- All of OSERS will have input through the National Council on the Handicapped, through ad hoc advisory groups, and through continual monitoring of correspondence. Their advice will be as carefully reviewed as that of our professional friends. Indeed, we will probably try to break that barrier between the person called “consumer” and a person called “professional”. Both are actually working for the same thing—effective rehabilitation.

AMERICAN REHABILITATION

Volume 7, No. 2 The weakest ink is better than the strongest memory. November-December 1981

3	Alcoholism—The Extra Burden	Thomas Brubeck
9	Access To The Skies	Ellis Reida
12	Legislation Affecting Rehabilitation of SSI and SSDI Beneficiaries	Joseph Abrams
18	PARs of SSI-SSDI Programs	Robert E. Patek
21	Addressing Psychological Needs	Barbara Jones
24	Review: Deaf Heritage	Edna Adler
26	Computerized Placement Service	Roger S. Decker and Sander VanderWerf
31	Solar Battery	

DEPARTMENTS

2	Topic of State	16	Notes on the Margin
7	IYDP	25	Language Used
15,20	New Publications	29	News, Notes, Announcements
		32	Report Resources

U.S. DEPARTMENT OF EDUCATION
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Jean S. Tufts, Assistant Secretary

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TOPIC OF STATE

Extensive Survey Completed In Cal.

The California Disability Survey, the most extensive study of people with disabilities ever undertaken in any state, was released by the Department of Rehabilitation on September 30. The survey showed that approximately 1.5 million people between the ages of 16 and 64 have disabilities severe enough to limit the type or amount of work they can do. This figure represents roughly 11 percent of the state's civilian household population in that age range.

The department contracted with the Survey Research Center at U.C. Berkeley and the Institute for Social Science Research at UCLA in 1976 to conduct the study. By use of an innovative computer assisted telephone method, the researchers were able to achieve an 85 percent response rate, reaching over 30,000 households in the state. As a result, data are now available which provide a clear profile of the state's population and with work or housework disability including information on type and severity of disability, location, age, race, sex, and other factors. The availability of these data can much improve the ability of the department and other agencies serving people with disabilities to tailor their services to the needs of the populations they serve.

...
A summary report of the survey is available on request by contacting Dr. Paul Mueller, Chief of Program Evaluation and Statistics, State Department of Rehabilitation, 830 K

Street, Sacramento, California 95814 (telephone (916) 445-9692, voice only). TDD users wishing to request the report by telephone can call the Communications Office at (916) 445-8638.

—*What's Happening*. California Department of Rehabilitation.

Job Club Started In R.I. Agency

"Some people say the hardest work you will have to do is the job of getting a job. It involves defining who you are, what you want and where you are going with your life." Richard Bolles, *What Color Is Your Parachute*.

Vocational Rehabilitation (in Rhode Island) is continuing to expand its placement services to handicapped individuals. The newest effort is a job club which began in May. In the club, members learn and immediately apply efficient job finding techniques under the guidance of a placement counselor. The job seeker treats job finding as a full-time job with one-half of each day devoted to obtaining job leads and arranging interviews and the rest of the day spent on actual interviewing. This schedule is followed every day until a job is obtained.

Members provide mutual assistance by sharing job leads and helping each other in improving phone techniques and interview styles and in expressing positive views of themselves and their capabilities. Individuals become excited and encouraged by others successes. Once learned and applied, the techniques can be used independently throughout the person's career.

—*Rehabilitation In Rhode Island*, Department of Social and Rehabilitative Services.

Delaware Council Given Official Nod

In signing Executive Order number 88, Delaware Governor Pierre S. Du Pont IV gave official status and recognition to the Council on Deaf Equality. In addition to its establishing the council, the order states the council's purposes, establishes its membership and their terms of office, and sets its meetings requirements.

The council was established informally in 1978 as a result of RSA Region III's annual meeting on vocational rehabilitation of deaf people. In the short span of its official tenure (the order was signed June 18, 1981), the state is already coming to grips with the critical problem of providing mental health service to its deaf population.

R.I. Data System Now In Place

Rhode Island Vocational Rehabilitation's Automated Data Processing System is now fully operational.

Since 1975, Rhode Island's Program Planning and Evaluation Unit has been developing a management information system for the agency. This computerization of agency functions utilizes a case management tracking system and time analysis of case statuses for counseling use.

As Rhode Island Vocational Rehabilitation opted to develop its own system rather than taking an already packaged program for other states, there were many "bugs" to be ironed out, but because of this, we feel that we have developed an excellent program that is readily adaptable to the

Alcoholism— The Extra Burden

Thomas Brubeck

As if disabled people do not have enough to cope with, it appears that many have the added problem of alcoholism. This probably comes as no surprise in a society where drinking is not only tolerated but is fashionable.

Being on the juice, as some put it, is no small matter for so-called normal people. For those with severe handicaps, it can be devastating.

The rejection, the feeling of uselessness, and the frustrations of the disability, itself, can easily lead to pathological use of alcohol. This kind of abuse is at least as common among disabled people as it is with the general public (8 percent of population). One hears many guesses, and some believe the percentage of alcohol abuse is higher among disabled people. But regardless of who has the sharpest pencil, we are talking about a minimum of 2.8 million disabled people who have taken on this added burden.

Some poignant comments from disabled people who like the coziness of neighborhood taverns provides insight into where they are coming from and the rocky road ahead:

"They like me there."

"I'm accepted."

"The people in the bar are not handicapped."

"I am less lonely; there is always

someone there to talk with."

"People know me there."

"My parents go to the tavern, too."

"When I'm drunk I am just like everyone else."

"Bars are always warm and friendly."

"In the bar I can be myself."

These comments were collected by Bella Selan of Mt. Sinai Medical Center in Milwaukee for a training institute at the Center for Social Service, University of Wisconsin-Extension. Frank Wenc of the University's Center for Alcohol and Other Drug Studies wrote about the developmentally disabled substance abuser in the winter 1980-81 issue of *Alcohol Health and Research World*. He said that developmentally disabled people, like others, "have learned from association, advertisement, and peer pressure that to be 'a somebody' and to meet and make friends it is important to participate in the rituals of the neighborhood. In many areas this means a lot of time spent at the bar."

Wenc adds that drinking is a great intellectual equalizer. "After all," he said, "there is a minimal difference in behavior between an extremely intoxicated nuclear scientist and an intoxicated deinstitutionalized window washer."

A fair number of disabled people might not perceive of themselves as having access to the neighborhood rituals, and they drink alone. A study of clients at the State Technical Institute and Rehabilitation Center (STIRC), a residential facility rehabilitating handicapped adults in Michigan, indicates that 37 percent of those surveyed were sometimes or predominantly solitary drinkers. The information indicates that the more frequently clients drink, the more they tend to drink alone.

The clients, about half of them severely disabled, were enrolled as trainees in 14 trade and technical departments. The study at STIRC, according to Garry Rasmussen and Ronald DeBoer, showed a drinking rate well above that of the general population. Out of 272 persons surveyed, 48 percent may be considered regular consumers (using alcohol at least 12 times a year), with 23 percent showing relatively frequent use of alcohol (more than once a week). About 17 percent reported never using alcohol.

Forty-four percent of the subjects reported that a member of their immediate family had had a drinking problem, and an additional 16 percent were not sure about drinking problems in their families.

Marijuana appears to be a popular psychotropic drug among STIRC clients, with 36 percent saying they have used it at least once and 29 percent reporting relatively regular use (at least six times a year). But there was an overall low rate of use of most other drugs. Regular use of illicit drugs was 4 percent of the total sample with the exception of the use of cocaine, reported at 6 percent.

About 35 percent said they were often bored, unhappy, or dissatisfied with their lives, and about 25 percent said they often feel frustrated and do not mix well socially. Many said they were not willing to talk about a personal problem. About 20 percent said they are "not sure" if they had a friend with whom they could discuss personal matters, and about 30 percent said they would probably not talk to someone else about personal problems.

There were questions about use of time outside of the classroom. While fewer than 10 percent felt they did not have enough free time, about 30 percent tended to feel uneasy about deciding how to spend their free time, and 45 percent tended to feel pressure to be productive during leisure time. About 27 percent reported having fewer than four recreational skills that could be used during their free time.

People who work with substance abuse at the Center for Independent Living in Berkeley, Calif., said that persons with disabilities run a high risk of developing alcohol and drug abuse on several levels.

Writing in NIAAA's *Alcohol Health and Research World*, Randi Hepner, Hal Kirshbaum, and David Landes said that, first, as a group disabled people have easy access to prescription drugs. Physicians will prescribe them because of real medical factors—pain or severe spasms—and

al societal attitudes toward disabled persons, including pity, guilt, and fear. They might feel that it is for the best, or all that can be done, given the "tragedy of the situation."

Second, disabled persons often take the handy path of drug misuse and abuse as a result of frustrations and anxieties about being thrust into an unproductive and dependent role.

Third, disabled persons are an oppressed minority, and the lure of alcohol and other drugs that promise relief, highs, and numbness can seem attractive.

Fourth, substance abuse often is the result of medical intervention and the rehabilitation process. At CIL, 41 percent of the clients said they had drugs prescribed which they felt were unnecessary. Drugs were taken in combination with alcohol by about 25 percent of the clients. The writers commented that valium, one of the most frequently prescribed drugs among the disabled community, "can become deadly" when combined with alcohol, or cause considerable damage to the body and brain.

The Veterans Administration operates about 100 alcohol dependence treatment programs. Alcoholism is a major health problem in the military services, and this remains a problem among veterans. In fact, alcoholism is the biggest single diagnosis in the VA healthcare system. About 3.2 million disabled veterans are served by VA rehabilitation centers for the blind, spinal cord injured, and other disabilities. There has been no attempt to assess alcohol problems among those with additional disabilities, but a study is now underway in this area.

About 5 percent of the people served in the state-federal vocational rehabilitation system, according to the Rehabilitation Services Administration, are classified as multidisabled

alcoholics (alcoholism, itself, is now considered as a disability). One to two percent are alcoholic with no other disability reported.

The Social Security Administration reports that about 7 percent of those applying for disability benefits suffer from alcoholism.

John Noble, deputy director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), suggests that few multidisabled alcoholics are receiving treatment for their alcohol problems. "Until now," he said, "the multidisabled alcoholic has been largely overlooked, both by the rehabilitation services system and alcoholism agencies."

Outreach to this special population has been minimal and the multidisabled alcoholic faces the dual stigma of alcoholism and another disability. Especially sensitive to this dual stigma are people who have epilepsy, who have lived with wild myths since biblical times, and deaf people, who have worked for years to get rid of the "deaf and dumb" label and do not want to add another label of "deaf and drunk."

Last year in Seattle, during the annual meeting of the National Council on Alcoholism, Nobel listed some of the internal and external barriers to recovery:

"Disabled persons, particularly the deaf and visually impaired, often believe that established agencies are unable to communicate with them; disabled persons may use alcohol to ease chronic pain and may be reluctant to give up this established coping mechanism; the prospect of participating in a separate alcoholism treatment program, at the same time they are involved in vocational rehabilitation, may be seen as too taxing; the dual stigma of alcoholism and physical or mental disability may deter the multidisabled persons from admitting



In drinking and in other matters, handicapped people could do worse than follow the advice of this quaint monument in Washington, D.C. About 3 million disabled people in the U.S. have taken on the added burden of alcoholism.

to an alcoholism problem; previous rejection by community service agencies may prevent the multidisabled alcoholic from seeking treatment; the limited income available to most disabled people may cause feelings that they cannot afford the cost of alcoholism treatment; a negative self-concept, reinforced by the fact of a physical or mental disability, may contribute to lack of self-motivation

to seek treatment; disabled persons may be unable to face guilt feelings relating to their alcoholism's role in causing the disability (in the case of accidents); and physical disability often creates dependence on others, contributing to the maintenance of alcoholism"

There is a new initiative within NIAAA's special treatment and rehabilitation division to underwrite dem-

onstration projects to explore such issues as the most effective route for service delivery—that is, whether to integrate services for disabled people into existing alcohol treatment programs or create special treatment efforts.

With its National Clearinghouse on Alcohol Information, NIAAA is developing a data base of both research and program information on the multidisabled alcoholic. Linkages will be established with national groups involved in rehabilitation services and alcohol treatment.

Underlying this initiative is legislation (PL 96-180 of 1979) directing the alcohol institute to encourage and fund the development of prevention and treatment services for this group. The law designates alcoholic people with additional disabilities as a priority target group for grant and contract programs.

The vulnerability of disabled people was noted in a report prepared by the U.S. Senate Committee on Labor and Human Resources prior to passage of the legislation. It stated, "Prevention programs targeted at handicapped children and young adults in school can reduce this vulnerability. In particular, since drugs are often required in the treatment of disabilities, handicapped students may face unusual risks if they drink, and should be informed of the dangers of combining alcohol with their regularly prescribed medicine. Treatment programs may not be accessible to the handicapped alcoholic Physically or mentally handicapped persons are, like the elderly, often discriminated against by the professional treatment network, where they are not viewed as desirable clients."

It is expected that as more disabled people are deinstitutionalized, there will be an increase in alcohol-related problems.

Speaking of Disability . . .

Heavy use of alcohol, America's most popular drug, is one of the three leading causes of birth defects involving mental retardation.

The National Institute on Alcohol Abuse and Alcoholism also tells us that alcohol is believed to be involved in about

- one-third of all suicides
- half of all murders
- half of all traffic fatalities
- a fourth of all other accidental deaths
- a leading cause of child abuse, marital violence, and rape.
- a contributory factor to cancer and to numerous diseases.

A number of high school students will be learning all of this firsthand, according to the agency. By the tenth grade, about seven out of ten adolescents no longer can be called abstainers, and three of them have alcohol-related problems.

Frank Wenc of the University of Wisconsin suggested that the detoxification facility—usually the first point of contact—designate a person as liaison to the developmental disabilities community. He said that a team of law enforcement, alcohol treatment, DD advocate, and medical personnel should develop a plan for the disabled alcohol-impaired person. The treatment should concentrate on meeting immediate needs, then following up with other services.

Clients usually receive an automatic referral to Alcoholics Anonymous. But for developmentally disabled persons—depending on such things as motivation, verbal skills, trained staff, and architectural barriers—the conventional AA approach can be wide of the mark. Sometimes another response is called for, such as having a volunteer take a disabled person to a self-help meeting in order to help in establishing relationships.

The Center for Independent Living advises that when a person is making major life changes, such as overcoming addiction, "continuous support is necessary." Suggested is the use of

two support groups weekly, combined with individual counseling sessions.

Prevention of substance abuse involves specialized work on the emotional and practical issues surrounding disability. CIL works with clients to achieve independent living skills, break down their isolation as disabled people, and learn to cope with the emotional issues. Achieving an independent lifestyle and learning to anticipate and cope with the emotional issues eventually helps them to recognize this golden nectar for what it is: yellow poison.

The agency seeks to develop assertiveness and encourage risktaking and problem solving. It provides a variety of direct services, including independent living skills training, peer counseling for individuals and groups, counseling or therapy for couples and families, medical counseling (nutrition, skin care, and other preventive health measures), and counseling about sexuality and disability.

There is referral, including audiologists, low-vision clinics, rehabilitation, and medical specialists.

In short, CIL does not view the treatment of an addiction as a luxury.

The main thing in intervention is to *stop* the use of alcohol. Once achieved, the trick is to "stay stopped." This is done by getting at the underlying problems and learning how to cope, according to the experts, who point out that some of the most intelligent people are found among the hard cases.

No one said it would be easy. But in what other area could intervention be as profitable? After all, there could not be many disabilities this deadly which can, with a little help, disappear altogether.

Mr. Brubeck is a public information officer with the Administration on Developmental Disabilities, Department of Health and Human Services.

TOPIC OF STATE

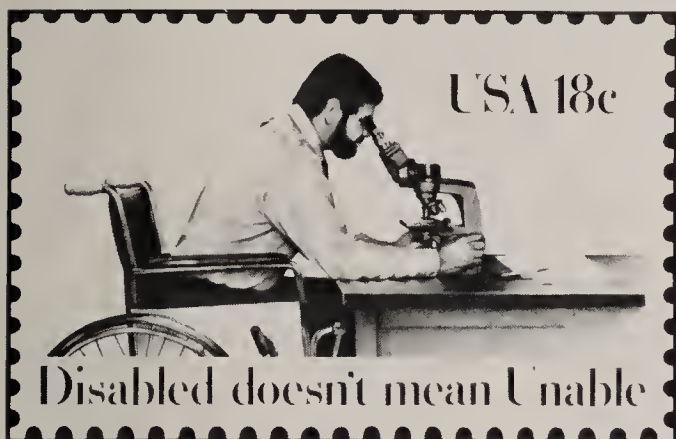
(Continued from page 2.)

needs of the agency. There are over 600 individual information bites that have been put into the program which allows for an easier retrieval of information. Over 100 items are incorporated to meet federal regulations and are also supplemented by the agency's needs. Such things that have been included are identification of clients, disability groupings, socioeconomic data, fundings, services provided, employer groupings and wages. Besides assisting management and counselors in the timely processing of cases, many special interest groups have been utilizing this system in increasing frequency to determine the needs of Rhode Island's disabled.

The Program Planning and Evaluation Unit is constantly designing more sophisticated programs so that additional information can be retrieved. At the present time the agency has its
(Continued on page 14.)

By Ned Burman

IYDP News And Notes From Here and There



This commemorative stamp was issued in June to call attention to the International Year of Disabled Persons. The stamp was designed by Mrs. Martha Perske of Darien, Connecticut.

"Disabled does not mean unable" is the text of the new commemorative stamp released by the United States Postal Service as an observance of the International Year of Disabled Persons. The new 18 cent stamp is in six colors and shows a young man in a wheelchair working with a microscope. The design was created by Martha Perske, a Darien, Connecticut artist.

The IYDP banner was carried to the summit of Mount Rainier in Washington by a group of disabled climbers who proved that a disability does not have to be a handicap. The group included seven blind, two deaf, one epileptic, and one amputee. The expedition reached the peak of the 14,410 foot mountain on July 4, 1981.

The Federal Communications Commission will review the unlicensed use of low power transmitters for educational programs for hearing impaired persons. A teacher can use earphones and this system to boost auditory levels when speaking with hearing impaired pupils.

Improved accessibility for disabled people was the key issue addressed by

the Special Programs and Populations Division of the National Park Service at a training session for regional representatives. Issues discussed included tactile display, new technology, signing, visual and performing arts, telecommunication, and audio/visual techniques.

In London, England, the IYDP Committee is sending an information packet on employment to the chairmen of the top 1000 companies in the nation. In addition, the committee asks that IYDP and employment be put on board agendas. It was suggested that attention be drawn to the need to ensure that their premises, services, and products be fully used by disabled people.

In Japan, the Nippon Television Network (NTW) is showing some 50 IYDP spots every day throughout the year. The spots cover rehabilitation, voluntary activities, disabled people active in the arts and other fields, and etiquette and courtesy toward people with disabilities.

"... For years we have voiced our concerns for international human rights. Many times we have criticized countries for their racial policies,

their oppressive child labor practices, for their denial of due process to the courts, for torturing political prisoners and incarcerating dissidents in mental institutions. "But somehow the disabled have been forgotten in our concern for human rights. We have forgotten that mental institutions rarely provide adequate care for anyone and frequently cause more damage; that the mentally retarded can also develop and grow if set free from the restraints of institutions; and the physically handicapped, also if provided the means to function in communities, can lead perfectly normal lives. "It is therefore appropriate to call attention to the special problems of the disabled and emphasize in the 1981 International Year of Disabled Persons that they are indeed part of the community entitled to the full range of human rights that we have proclaimed for others." Rev. Theodore M. Hesburgh, CSC., President, University of Notre Dame.

"It's a New Day" is a worthy successor to *"A Different Approach"* which won over 20 awards, including the Academy Award nomination for Best Live Action Short Subject category in 1978. The new film celebrates the new technologies and the new attitudes that are making it possible for disabled persons to fully participate in the mainstream of community life. *"It's a New Day"* is the second in a series of films sponsored by the South Bay Majors Committee for Employment of the Handicapped in Los Angeles. Singer-composer Danny Deardorff is featured singing one of his own compositions *"Run Like a Thousand Horses."*

For information, write or telephone the South Bay Mayors Committee for Employment of the Handicapped, 2409 N. Sepulveda Blvd., Suite 202, Manhattan Beach, California 90266, phone: (213) 545-4596.



International Year of Disabled Persons 1981

Access To The Skies: A New Program Model

Ellis Reida

A worldwide program to develop the cabins of commercial passenger aircraft to be more accessible for handicapped people is opening new vistas for effective cooperation between the private sector and relevant government agencies. Called "Access To The Skies," and created by Rehabilitation International U.S.A., it has mobilized the resources and developed corporate involvement, from all of the air frame manufacturers in the free world and a majority of the world's air carriers.

This program, which is the first to mobilize an entire industry internationally to focus on the solution of a human problem, has far-reaching implications for future programatic efforts to serve handicapped people, both nationally and internationally.

The program has several unique features. For more than 2 years, a number of aircraft corporations have allocated inkind services and internal budgets to various research and development activities. The Lockheed-California Company, the Boeing Commercial Aircraft Co., Airbus Industrie, Pan American World Airways, United Air Lines, the Scandinavian Airlines System, and Aer Lingus are only some of the companies which have contributed comprehensive services and funds to it. In 1981 the United Technologies Corporation has made possible an expan-

sion of the program with a large grant for coordination and research not covered by individual carrier and manufacturer activities.

The Problems

The problems facing the disabled passenger in an aircraft cabin are formidable. Airport wheelchairs do not transverse the narrow aisles and nonambulatory passengers must be manhandled into seats. The seats, themselves, with their rigid aisle arms, present a dangerous obstacle to disabled passengers in that they must somehow be lifted over the seat arms with the possibility of bruises and abrasions.

The most serious problem, (and from an engineering standpoint, the most difficult to correct) is the inaccessibility of the lavatory. Until now, a nonambulatory passenger must be loaded onto an aircraft before the other passenger, and the handicapped person must wait to be deplaned after all the other passengers are off. When this time is added to the time of long flights (the New York-Tokyo flight is 14 hours, for example) it presents disabled passengers with an intolerable situation. Either they can't fly, or they must use drugs, engage in preflight fasting, and so on, in order to stand the rigors of the trip.

The carriers and manufacturers generally were reluctant to become

involved at first. They had concerns that pressures would demand the enlargement of lavatories, the widening of aisles, and other engineering design changes the costs of which would be prohibitive. The program, however, took the position that these corporations know more about engineering their planes than any one else. Thus, the problems of disabled people were described to them, and they were left to propose solutions that were compatible with their other needs. This approach had the effect of changing the dynamics of the relationship from one of defensiveness to that of creative involvement. Industry began to look at the problem, instead of defending "turf." The result was a flow of innovative suggestions which had the effect both of cost reduction and potential increased service.

There was a crucial missing link, however. While aircraft engineers are extremely knowledgeable about aircraft design, they have no knowledge of disability characteristics and how these characteristics affect design. Rehabilitation specialists often forget the fact that their knowledge tends to be restricted to their own field, and that those in other professions may have only the most rudimentary concepts about handicapped people. One cabin engineer, for example, who had been working on design problems concerning handicapped people for 29

or 3 months and already had learned something about the problems, asked one day, "What's the difference between a paraplegic and a quadriplegic?"

Rehabilitation Resources

Thus, it was essential to the program to have the assistance of rehabilitation centers and personnel to interact with the aircraft design engineers to assist them in understanding the characteristics that they were designing to meet. The Daniel Freeman Hospital Medical Center provided invaluable assistance to the program in this fashion in 1979 and 1980. The Centre de Readaption in Mulhouse, France, became a European center for such service. Dr. Paul Dollfus, Medical Director, and also Chairman of the International Commission on Technical Aids, Housing and Transportation of Rehabilitation International, held a number of conferences at the centre, and had a major role in the mobilization of the European aircraft industry.

Unable to assist the program with direct funding, primarily because of budget constraints, the United States Government nevertheless provided important assistance by providing expertise in the area of greatest need, the interaction between rehabilitation engineering and aircraft design.

The Rehabilitation Engineering Center of the University of Virginia is an example of this government role. The engineering director of the center, Dr. Colin McLaurin, early became a major participant in the program, offering consultation and advice. Further, under his direction, Ted Bruning of the center developed a prototype onboard wheelchair to meet the major need, the capacity to get the disabled passenger from the aircraft seat to the lavatory and back during flight. Dr. McLaurin has at-



This special wheelchair, which helps make air travel easier for disabled people, was developed by Rehabilitation International-U.S.A. Called the Fulton Wheelchair, its narrow design allows it to fit in the plane cabin and fly with the passenger.

tended all meetings, both in the United States and Europe, and, as chairman of the program Technical Advisory Committee, has had a significant influence in the education of aircraft engineers in the needs of the handicapped person.

Another valuable government contribution came from the Research and Training Center of the University of Washington at Seattle. There, C. Gerald Warren, Director of Research, worked closely with the Boeing Commercial Airplane Co. in devising lavatory accessibility in Boeing planes.

Early Activities

It is ironic that Rehabilitation International U.S.A. did not initially plan to develop an aircraft accessibility program. At an open meeting in Washington, D.C., in October, 1977, RIUSA, which was initiating an international travel program for handicapped people, asked the invitees (who came from all sectors of the rehabilitation community and business)

to recommend priorities for action.

Surprisingly, a major focus was given to the airplane. While a majority of handicapped people do not fly, the disabled people who were at the meeting did fly, and found the airplane to be a great problem. Further, the plane had become a symbol of barriers. As the most expensive item of equipment by far that is used in travel, it seemed to present an immovable block to the development of accessibility across the board.

A key person at the first meeting was Bill Kocis, Manager, Cabin Service Systems, Pan American World Airways. Bill became interested in the problem and, working with Robert Fulton, jr., aeronautical engineer, inventor, and Chairman of the Access To The Skies program, for the next few months looked at possible accessibility concepts. By spring, a number of seemingly feasible approaches to the problem had been proposed. In the fall of 1978, RIUSA formally introduced the program, and Mr. Itzhak Perlman, who made the public announcement, accepted the honorary chairmanship.

Shortly afterward, a major event occurred. The Aerospace Industries Association formed a special committee, the TARC 218-2 Committee, to review the problems of accessibility in aircraft and make recommendations for improved designs. Members of the committee were Boeing, McDonnell-Douglas, and Lockheed, with Airbus Industrie later joining as an associate. Under the able chairmanship of Peter Kavaloski, Senior Design Engineer (L-1011) at Lockheed, the committee moved rapidly to collect information and identify needs. During this period, the Daniel Freeman Hospital Medical Center offered important assistance to the committee in its activities.

The Air Transport Association had early indicated approval of the aims and directions of the program, but for procedural reasons awaited the results of the TARC 218-2 investigations of the AIA. This task was completed in 1980 and a final report was written. After review, it was forwarded to the ATA, which then initiated its own actions. In the meantime, the International Air Transport Association (IATA) issued new regulations comprehensively increasing services to handicapped people by its member air carriers.

Objectives Accomplished

No presently flying plane has an onboard wheelchair, and, consequently, no nonambulatory passenger has the capacity to leave his seat in flight. Thus, a primary research focus was to develop such equipment. Besides the wheelchair developed by the University of Virginia which focussed on lightness, stowability, and ease of operation, other chair designs were produced.

The Lockheed-California Company, in partnership with the Carrier Aircraft Co., a major producer of aircraft seats, developed a prototype wheelchair with a different focus, the fullest possible service. It featured the ability to enter the lavatory and allow the disabled passenger actually to translate over the toilet while remaining in the chair.

Robert Fulton, Jr., designed a third chair which has the capacity to meet the disabled passenger at his car and transport him to the plane and to his seat. It also has special stability features in the airport, the capacity to take the disabled passenger from the tarmac to the plane cabin door, and a special stretcher feature. One version also has a builtin commode in the seat.

All program designed wheelchairs

can move down the aisles of all presently flying commercial passenger aircraft (of over 50 seats). All can be stored onboard. And all can enter the lavatory.

At the same time, work has progressed on developing more accessible features in the lavatories, themselves. By the spring of 1981, several airlines reported work in progress or completed in developing at least some accessible lavatories in their aircraft.

Another problem which has been identified early was the need for some type of movable arm on the aisle seat to facilitate the transfer to and from it. American aircraft seat manufacturers began working on the problem, and, by the beginning of 1980, had prototype aisle seat arms for demonstration. Early in 1981, at least one company already had a production model.

Future Aims and Goals

In 1981, the Access To The Skies program, with the cooperation of a number of air carriers, will continue testing the various types of prototype equipment which has been developed, culminating in flight testing in mid year. Then recommended design changes, if any, will be made. By the end of the year (The International Year of Disabled Persons), the completed package should be ready for air carriers worldwide to begin installation.

The program has not forgotten the problems of the deaf, blind, speech impaired, and other disabled groups, which are receiving special attention. The reason, however, for the emphasis on the problems of the nonambulatory passengers as a first priority was that this type of disability presented the most formidable engineering obstacles, and they had to be overcome in order for the program to have significance in other areas.

It is important to underline the fact that the disabled, themselves, have attended all meetings of the program, and have been involved in all testing and evaluation procedures. Further, four members of the leadership group, who have guided the program, are disabled. The Paralyzed Veterans of America has agreed to provide systematic involvement of the disabled in all program aspects, and to offer advice and counsel as needed.

Summary

The Access To The Skies program has developed a new program model which can have great significance in future rehabilitation services. In this model, industry, itself, provides the great bulk of funding and research. Industry also provides the expertise and research facilities, insuring that the work done is apt, up-to-date, and in accordance with industry needs and norms. Finally, the fact that industry has set the ground rules, so to speak, and has taken the leadership in developing the service and program focus, tends to guarantee industry acceptance of the results and their implementation. The contrast with Transbus can be instructive.

It is necessary, in closing, to express the sincere appreciation of the Access To The Skies program, and those associated with it, to the rehabilitation facilities and personnel who have done so much to make the program a success, including the University of Virginia, the Daniel Freeman Hospital Medical Center, and the Centre de Readaptation.

Even more important is the need to thank the numbers of engineers, flight personnel, and executives in the various aircraft manufacturing companies and air carriers without whose expertise and enthusiastic goodwill the program never could have been successful.

Legislation Affecting The Rehabilitation Of SSI And SSDI Beneficiaries

Joseph Abrams

President Reagan signed the Omnibus Reconciliation Budget Act of 1981 (P.L. 97-35) into law on August 13, 1981. That law contains a number of amendments to the Social Security Act which have an important impact on the rehabilitation of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) blind and disabled beneficiaries. The provisions on federal payment of the service costs associated with successful rehabilitations of these two severely disabled beneficiary groups were highlighted in the September-October issue of *American Rehabilitation*. These provisions are also included in the amendments summarized in this article.

In addition to financing the cost of rehabilitation services, the amendments to the Social Security Act selected for summarization here relate to cash benefits, medical benefits, and other provisions which have a major bearing on the rehabilitation of SSDI and SSI beneficiaries. This compilation has been designed to serve as a convenient reference for those in the rehabilitation field that work with these particular disability groups.

SSDI Provisions

1) *Financing VR Services*. Eliminates reimbursement from the Social Security Trust Funds to the state vocational rehabilitation (VR) agencies for rehabilitation services except in

in the SSDI beneficiary's performance of substantial gainful activity for a continuous period of 9 months. Such 9-month period could begin while the person is under a VR program and may also coincide with the trial work period and during the person's waiting period for benefits. The services must be performed under a state plan for VR services under title I of the Rehabilitation Act. In the case of any state which is unwilling to participate or which does not have a plan which meets the requirements of the Vocational Rehabilitation Act, the Commissioner of Social Security may provide such services by agreement or contract with other public or private agencies, organizations, institutions, or individuals.

Payments to the states shall be made in advance or by way of reimbursements, with necessary adjustments for overpayments and under payments. There is no limitation on the number of beneficiary cases that can qualify for reimbursement; however, the Secretary of Health and Human Services (HHS) shall determine the total amount to be reimbursed under this provision and may limit by regulations the type, scope or amount of services to be reimbursed. The determination that the VR services contributed to the person's successful return to work and the determination of the costs to reimburse shall be made by the Commissioner of Social Security. Payments under this provision shall be made in advance or by way

of reimbursement, with necessary adjustment for overpayments or under payments.

The provision would be effective as to services rendered October 1, 1981 and thereafter. A similar provision applies to reimbursement from the Federal Treasury for the cost of such successful rehabilitations of SSI blind and disabled beneficiaries.

2) *Minimum Benefits*. Eliminates the minimum social security retirement or disability benefit for all present and future beneficiaries. The amount payable to people already receiving benefits based on the minimum primary insurance amount (which is basically \$122 a month) would be recomputed, based on their actual earnings record and according to recomputation procedures to be prescribed in regulations issued by the Secretary of HHS. All benefits payable to new beneficiaries would be based on their actual earnings, with no minimum payment level, effective for benefits payable after November 1981 for newly eligible beneficiaries, and for all other (current beneficiaries) beginning with benefits payable March 1982.

3) *Disability Benefit. Megacap and Workers' Compensation Offset*. Provides for a *disability Megacap*, under which a person's social security disability benefits will be reduced (if necessary) so that the sum of all benefits payable under federal, state, and local public programs on the basis of disability will not exceed the higher

of 80 percent of the person's "average current earnings" or the disabled-worker family's total social security benefits. This provision, however, will not reduce a person's social security disability benefits based on his or her receipt of a Veterans Administration (VA) service-connected benefit; a public-employee pension, based on employment covered under social security; a needs-based public benefit; or a private pension or insurance benefit. The provisions of the Megacap offset are generally similar to those of the Workers' Compensation (WC) offset provision of current law, but are more inclusive. This also modifies the WC provision in current law by extending the offset to disabled workers aged 62-64.

This provision is effective with respect to initial entitlements to OASDI disability benefits for months after August 1981, but only in the case of people who became disabled after February 1981.

4) *Terminate Mother's and Father's Benefits When Child Attains age 16, Except Where There Is An Eligible Disabled Child.* Ends entitlement for the mother or father caring for the child who receives child's benefits when the child reaches age 16 (rather than age 18, as under current law). *This change does not apply in the case of a parent caring for an eligible disabled child aged 16 or over.* The provision is effective with respect to current beneficiaries only at the end of August 1983 (2 years after the month of enactment), but is effective immediately for parents becoming newly entitled to benefits for months after August 1981. Benefits to children are not affected by this change.

SSI Provisions

1) *Financing VR Services.* See first item under preceding SSDI provisions. This provision for reimburse-

ment of the cost of services to successfully rehabilitated SSI beneficiaries is effective October 1, 1981, the same as for SSDI beneficiaries.

2) *Health Services for SSI Children.* Removes the mandatory referral of disabled or blind children under the age of 16 for medical, educational, and social services and deletes the funding authority to provide reimbursement to states that provide such services to SSI recipients who are under age 16. The provision is effective October 1, 1981. Children's services programs are included under the Maternal and Child Health Services Block Grant Act.

Medicare Provisions

Individuals who are entitled to SSDI benefits for 2 years or more are eligible for Medicare.

1) *Increase in Part A (In-patient Hospital Care) Deductible.*

Current Law: A beneficiary is required to meet a deductible which is intended to cover the cost of one day of inpatient hospital care in a spell of illness. The part A deductible (\$204 for calendar year 1981) is mathematically derived through a formula using a base figure of \$40. Coinsurance charges are imposed for additional covered inpatient services. Such charges are a fraction of the basic deductible amount.

Modification: This provision raises to \$45 the base of the formula that is used in the determination of the part A deductible. For calendar year 1982, the deductible will equal \$256 instead of \$228. Coinsurance amounts will be figured on this new amount.

Effective Date: January 1, 1982.

2) *Increase in Part B (Supplemental) Deductible.*

Current Law: Under the supplementary medical insurance program, Medicare beneficiaries are generally required to incur \$60 in expenses for

covered medical services in a calendar year before the program will begin making payments.

Modification: This provision increases the \$60 deductible to \$75.

Effective Date: January 1, 1982.

3) *Limitation on Reasonable Cost and Reasonable Charge for Outpatient Services.*

Current Law: Medicare recognizes no upper limit on reasonable costs or charges for outpatient services furnished by hospitals, community health centers, and clinics.

Modification: The Secretary of HHS is required to establish, by regulation, to the extent feasible, limitations on costs or charges that will be considered reasonable for outpatient services provided by hospitals, community health centers, or clinics and by physicians using these facilities. Actual charges will be used in developing the limitations, which are to be reasonably related to the charges in the same area for similar services provided in physicians' offices. The limitations do not apply with respect to *bona fide* hospital emergency room services. The Secretary may also provide exceptions to these limitations in cases where similar services are not generally available in physicians' offices in the area.

Effective Date: Upon enactment (Aug. 13, 1981) subject to future regulations.

Medicaid Provisions

SSI recipients are eligible for Medicaid. The following provisions relate to flexibility for the states in providing for Medicaid.

1) *Reimbursement of Hospitals.*

Current Law: State Medicaid programs are required to pay for inpatient hospital services on a Medicare reasonable cost basis unless an alternate reimbursement method has been approved by the Secretary of HHS.

Modification: The current law provision for "reasonable cost" reimbursement is replaced by a new requirement. The states must make assurances satisfactory to the Secretary that the rates paid hospitals are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in accordance with applicable laws and quality and safety standards. The rates paid must take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, serving large numbers of low income patients. States must also assure that the rates paid provide reasonable access to inpatient hospital services of adequate quality.

Effective Date: Applies to services furnished on or after the date final regulations (including interim final regulations) are promulgated to carry out this section.

2) Removal of Medicaid Reasonable Charge Limitation.

Current Law: State Medicaid payments for physicians' services and certain medical supplies and laboratory services cannot exceed reasonable charge levels established under Medicare. In addition, state plans must provide for methods and procedures to assure that payments under the state plan are not in excess of reasonable charges.

Modification: This provision repeals the reasonable charge limit requirements, as well as the requirement that state plans provide for methods and procedures to assure that payments are not in excess of reasonable charges.

Effective Date: Effective for services furnished on or after October 1, 1981.

3) Waiver to Provide Home and Community-Based Services for Certain Individuals.

Current Law: Federal matching is only available under Medicaid for "medical assistance," that is, for services which are primarily medical in nature.

Modification: The Secretary may by waiver allow a state to include under its plan approved home- or community-based services, except for room and board, to people who, without these services, would require care in a skilled nursing facility or intermediate care facility which would be paid for under the state plan. States may include case management services, homemaker/home health aide services and personal care services, adult day health, habilitation services, respite care, and other services requested by the state which the Secretary approves. Such services must

be provided pursuant to a written plan of care.

Effective Date: 90 days after August 13, 1981.

Mr. Abrams is senior staff specialist of the Rehabilitation Services Administration in the area of SSDI/SSI-VR.

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3) *Summary of Medicare and Medicaid Amendments of 1981* by Health Care Financing Administration, August 4, 1981.

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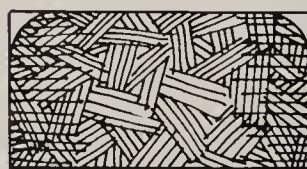
own inhouse programer which facilitates information retrieval. The system has a built-in security system for confidentiality of clients.

Future plans will call for incorpo-

rating fiscal data that can be monitored on a daily basis which will additionally help management in the day-to-day operation of the agency.

—*Rehabilitation In Rhode Island*, Department of Social and Rehabilitative Services.

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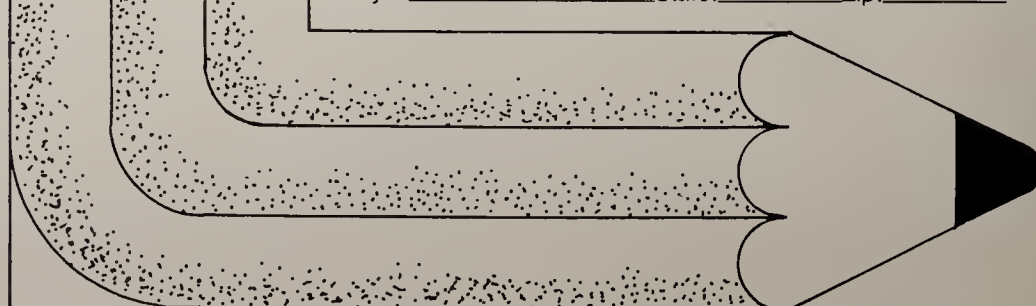


If you find in **American Rehabilitation** the kind of material that informs or that is useful to you in some way, a colleague who does not receive the magazine may also profit by it. If you know such a person, fill out the blank below and send it to Editor, **American Rehabilitation**, Room 3525, 330 C street, S.W., Washington, D.C. 20201. We will be happy to send your friend a sample copy of the magazine.

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PUBLICATIONS & FILMS

Comback. Six Remarkable People Who Triumphed Over Disability. Frank Bowe. Harber & Row, 10 East 53rd St., New York, N.Y. 10022. 172 pages \$12.50.

First reaction to the title: "Well, here's another of those triumphs over adversity, the sharks of the disabled world!" And, admittedly, it is. There is nothing wrong with overcoming. It's a source of pride for the overcomer, as well as a source of inspiration to others.

But this book's greatest asset lies in a comparative direction, in the direction of method. While the subjects share the disabilities, the struggles, and the successes and failures, they attain their goals in a variety of ways. They are, then, like many people; that is, in the essentials of living, they represent a variety that is found in society at large.

Much of its success will lie in the easy approach that the author takes in presenting the lives. He can choose the interesting descriptive details without overburdening us with minutia. The impression in all six cases is understanding of the person. The author is well qualified having written two successful books (*Handicapping America* and *Rehabilitating America*) and being himself a deaf person who could easily have been included among the six profiles.—**Ron Bourgea**

Handbook of Severe Disability. A text for rehabilitation counselors, other practitioners, and allied health professionals. Walter C. Stolov, M.D., and Michael R. Clowers, Ph.D., editors. Published by the Rehabilitation Services Administration and available through Superintendent of Documents, U.S. Government Printing Of-

fice, Washington, D.C. 20402. 445 pages. \$14, hardback.

As a person who was at least minimally involved in publications distribution, I can attest to the need for this volume as a replacement for the popular and much-requested, *A Survey of Medicine And Medical Practice*. The latter was first published in 1966 and enjoyed immediate success as a counselor's guide to medicine and medical practice. It was reprinted in 1969 and again in 1974.

In all its chapters, definition is a crucial ingredient of the topic at hand. But nowhere will you find a more graphic and absorbing (and entertaining) description of disability as in Dr. Stolov's opening chapter on evaluation and treatment. This is followed by chapters on psychological adjustment to chronic disease and a discussion of various bodily systems.

The remaining 29 chapters survey various diseases and conditions (spinal cord injury, multiple sclerosis, diabetes, alcoholism, burns, sickle cell disease, etc.). Most of these chapters rather uniformly follow a set sub-headline pattern of disease description, functional disability, standards of evaluation, total treatment, and vocational implications. Also, most of the chapters present a bibliography on the topic of discussion. The patterned structure, however, has by no means obstructed the presentations, since each author further breaks the general categories into units that best adapt to his presentation. And, in this regard, I have sampled several chapters and found the sometimes complex subjects eminently well presented and easily assimilated.

The value of this volume is enhanced by a profusion of photographs

and illustrations. It is also indexed, many of the main categories further broken down into particular subject areas. Finally, a substantial glossary defines the many technical words that are used in the text.

Perhaps based on the popularity of its predecessor, the editors welcome comment from the reader by writing to Walter C. Stolov, M.D., Department of Rehabilitation Medicine, RJ-30, School of Medicine, University of Washington, Seattle, Washington 98195.—**Ron Bourgea**

The Best Years Of My Life. Harold Russell. Paul S. Erikson, Publisher, Battell Building, Middleburg, Vermont 05753. 192 pages. \$11.95.

Harold Russell—Academy Award-winning actor, bestselling author, advisor to six U.S. Presidents—has just completed his second book, his autobiography.

Russell, who lost his hands in a World War II Army training accident, tells (with journalist Dan Ferullo) how he made the most of what was left. He speaks fondly of his lasting friendship with the famous Hollywood director, William Wyler. Wyler cast Harold in "The Best Years of Our Lives" and the movie made him an instant international celebrity, changing the course of his life forever.

It is the years after the movie that the author speaks of with so much humor. He tells of his experiences as an actor in Hollywood, in government as chairman of the President's Committee on Employment of the Handicapped, of his globe-trotting tours on behalf of the World Veterans Federation, as national commander of AMVETS, and as a leader in the fight to improve the lives of the handicapped the world over. His life has been a colorful one and it's all here in his new book.

Notes on the margin...

Three items on deafness

. An important spin off of the Arizona Association of Rehabilitation Facilities Section 311 outreach project for discovery and service to deaf people in rural areas is the establishment of eight trilingual interpreters (Navajo, English, and sign language) for the deaf on the Navajo Reservation where there were none before. CETA funds from the Governor's discretionary allotment were made available to help in this development, which includes a curriculum for sign language medical interpreting.

. An ear bioengineer at the University of Utah is working on an ear implant system that is enabling deaf people to hear and understand about 75 percent of simple words, including similar sounding words read to them. Dr. Donald Eddington and other bioengineers expect eventually that an electronic ear with as many as 5,000 electrodes will be developed for implantation in deaf babies at birth and in deaf adults with near normal hearing anticipated for the latter. Presently, they are working with six electrode implants.

. Robert Sanderson, Ed.D., State Coordinator of Vocational Rehabilitation Services to the Hearing Impaired in Utah has been selected for the Powrie Vaux Doctor Chair at Gallaudet College for the 1981-82 academic year. The chair provides important opportunities for study and writing. Mr. Sanderson, a deaf man, is a Gallaudet graduate. He was an early participant in the RSA-California State University, Northridge sponsored National Leadership Training Program in Deafness and earned his doctoral degree at Brigham Young University.

Talking book

Minnesota's Radio Talking Book Calendar continues to be a publication of exceptional value not only for its listings of radio talking book programs, but for the many indepth sketches

of interesting people that it features. The service is on the air for 19 1/2 hours daily and serves a clientele of about 6,000 throughout Minnesota and in sections of North and South Dakota. There is also a braille edition. The service is programed and broadcast by the Minnesota State Services for the Blind and Visually Handicapped in collaboration with Minnesota Public Radio, Inc., Cable system companies.

Exercise system

The Hissom Memorial Center, a school for mentally retarded people in Oklahoma, now has a parcours. What's that? It is a French word that means "course," and is used to designate a physical fitness trail in which the participant makes his way to different stations and completes the exercises prescribed at the station. (Example: The station shows an outline figure of a person doing a chin-up, then explains the procedure briefly in writing. It also lists the recommended quantity of exercise for beginner and advanced participant. The Hissom parcours is a 2-mile course that has 20 exercise stations.

Internships available

Applications are available for the Graduate Internships in Vocational Rehabilitation Counseling offered at the suburban Philadelphia branch of the Devereux Foundation, a group of multidisciplinary residential treatment, special education and rehabilitation centers. The Devereux Pennsylvania Branch is approved by the APA for Pre-Doctoral Internships in Counseling and Clinical Psychology. The Career House Unit is approved by the International Association of Counseling Services as an Accredited Counseling Center. The Vocational Rehabilitation Center is approved by CARF--The Commission on Accreditation of Rehabilitation Facilities. Information and applications are available from Dr. Henry Platt, Director, The Devereux Foundation, Institute of Clinical Training, Devon, Pennsylvania 19333.

Program Administrative Review Of SSI - SSDI/VR Programs

Robert E. Patek

The Rehabilitation Services Administration, an agency of the Department of Education, administers the programs which serve physically and mentally disabled citizens. The Rehabilitation Act of 1973, as amended, provides the statutory basis for the agency. It also establishes numerous programs through which handicapped people attain economic independence and a richer quality of life.

Vocational rehabilitation is a major governmental program involving a state-federal partnership. The vocational rehabilitation process involves a comprehensive evaluation, individualized plans of services, a personal relationship between the counselor and client throughout the rehabilitation process, including assistance with post employment services, as needed. Vocational rehabilitation involves a multidisciplinary approach in which services are provided by qualified personnel in varied settings, such as sheltered workshops, rehabilitation centers, hospitals, schools, etc.

During the F.Y. 1980/1981 period of the Social Security Disability Insurance (SSDI)-Supplemental Security Income (SSI)-VR review Section 222 of the Social Security Act provided for the payment from the Trust Funds of costs of vocational rehabilitation services furnished to disability beneficiaries. Within the limits authorized under Section 222, Trust Funds were available to the states to

provide for vocational rehabilitation services (and related costs of administration) for disability beneficiaries under state vocational rehabilitation programs. This provision made vocational rehabilitation services more readily available to disabled people and resulted in a savings to the Trust Fund as expenditures for VR services were offset by benefit terminations and FICA contributions.

During FY 1980, 15,034 people who receive social security disability insurance benefits were rehabilitated, with all or part of their rehabilitation costs paid from the Trust Funds. An additional 15,026 beneficiaries who did not meet the special selection criteria for the use of Trust Funds were rehabilitated with basic support (Section 110) funds—the traditional funds under the Rehabilitation Act.

The Supplemental Security Income (SSI) program was enacted as Title XVI of the Social Security Act under the amendments of 1972 (P.L. 93-603). Effective January 1, 1974, the state grant program for aid to the aged, blind, and permanently and totally disabled was replaced by the Federal SSI Program administered by the Social Security Administration. The vocational rehabilitation aspects were authorized in Section 1615 of the Social Security Act and provided for the referral of SSI recipients who were disabled by blindness and other causes, who were under the age of

65, to the state vocational rehabilitation agencies for consideration of approved vocational rehabilitation services; the full federal payment of the costs incurred in providing such services from funds appropriation for this purpose; and mandatory acceptance of vocational rehabilitation services. A disabled person who refuses such services without good cause cannot qualify for SSI payments.

During FY 1980, 9,434 recipients of SSI disabled-blind benefits were rehabilitated with all or part of their rehabilitation costs paid from SSI funds for vocational rehabilitation. An additional 12,093 recipients, who did not meet the special selection criteria required for the use of SSI funds to pay costs of vocational rehabilitation were rehabilitated with the use of basic support (Section 110) funds.

Beneficiaries of both programs must be selected for services in accordance with special selection criteria established by the Secretary of Health and Human Services. Those people who were selected must have impairments that, without vocational rehabilitation services, were expected to remain severe and of long term duration but who, after receiving services could reasonably be expected to engage in work long enough to offset the cost of their rehabilitation. To receive special funds for vocational rehabilitation, each state agency was required to submit an amendment to its

state vocational rehabilitation plan that sets forth its policies and procedures for providing vocational rehabilitation services to beneficiaries under the Rehabilitation Act of 1973 and to meet the conditions prescribed in the Social Security Act.

The state-federal vocational rehabilitation program was selected to administer the Special SSDI/SSI-VR Programs because of its long history of helping disabled people achieve employment and its demonstrating the unique ability to meet the needs of severely handicapped people. During their deliberations on the 1965 Amendments, Congress decided that, although the arrangements up to 1965 had facilitated the rehabilitation of some disability beneficiaries, the number who were receiving rehabilitation services under the state-federal vocational rehabilitation provisions remained too small (about 3,000 were rehabilitated annually). Because many states fell short of matching VR funds, limitations on facilities and services constituted obstacles to the rehabilitation of a greater number of social security beneficiaries.

Under those conditions, the states were not able to provide services for all handicapped people who could benefit from them. It was natural that they give priority to people who had the best rehabilitation potential. Social Security disability beneficiaries, who were likely to be more severely disabled than most applicants, generally did not represent the best investment of the state's rehabilitation resources; therefore, they often had a lower priority than other applicants. Consequently, 100 percent federal funds were provided to promote the rehabilitation of a greater number of beneficiaries.

Program administrative reviews (PAR) were instituted by RSA in FY 1976 for all agencies in the SSDI/SSI

programs. The computerized PAR results lend themselves to use as a management tool by state directors and coordinators through the identification of interrelationships of critical variables and the comparison of results regionally and nationally.

The FY 1980-81 PAR focused on the review of current cases (active and closed) in achieving the following objectives:

- To collect and computer analyze case folder data in order to identify areas of strength and weakness in program administration;

- To assure that state agencies were providing services in accordance with the Rehabilitation Act of 1973, as amended and Sections 222 and 1615 of the Social Security Act, as amended;

- To assist state agencies to improve services as required through federal technical assistance and consultation;

- To cause a reduction in the amount of improperly expended federal funds, and to reduce the possibility of future audit exceptions; and

- To provide information for program planning.

Casework practices of primary concern were the current verification documentation, special selection criteria (SSC) certification; significant services; rehabilitation employment outcomes, and SSA-853 closure reporting.

In response to findings from the 1976 PAR, which indicated a substantial range in state agency performance, and to the GAO Report (May 13, 1976), which emphasized the need for improved program accountability, RSA established SSDI/SSI VR Program Performance Levels. For FY 80-81 these were:

- In no less than 90 percent of all clients whose case services were charged to the trust funds or SSI VR

funds, all four special selection criteria must have been met.

- In no less than 90 percent of the SSDI/SSI closures, VR services must have contributed significantly to the rehabilitations.

- In no less than 95 percent of all SSDI/SSI closures, a properly completed and timely form SSA-853 must have been submitted to SSA.

The method used for the evaluation of performance was to be the program administrative reviews.

The sample of cases for each agency was selected under strict random sample techniques by the regional offices or through a state agency computer-generated random sample and was comprised of a maximum of 80 cases—40 active and 40 closed rehabilitated (SSDI and SSI). The closed cases were selected from those closed within the preceding 6 months and the active cases from those certified as meeting the special selection criteria within 6 months prior to the PAR. If fewer than 20 cases were available in any category, 100 percent of the cases were reviewed.

The 1980/81 PAR data was computer tabulated and analyzed. All data was tabulated for SSDI and SSI closed and active cases, and multiple variables were combined in an analysis that allows state agencies to compare their individual findings with similar organizations, regionally and nationally, and to indicate areas of strength and weakness that require reinforcement or assistance.

To summarize the findings:

- 82 program administrative reviews were conducted (53 in general agencies and 29 in agencies for the blind).

- 5,081 cases were reviewed (active—1,439 SSDI and 1,206 SSI; closed—1,330 SSDI and 1,106 SSI).

- 95.2 percent active cases and 95.1 percent of closed cases met all

four of the special selection criteria.

- 99.1 percent active cases and 99.3 percent of closed cases met the first special selection criterion which disallows the use of trust funds for rehabilitating those people who have rapidly progressive impairments.

- 98.6 percent active cases and 97.6 percent of closed cases met the second SSC criterion which disallows the use of trust funds for rehabilitating those people who would medically recover without VR services.

- 96.6 percent active cases and 97.4 percent of closed cases met the third SSC criterion which limits the use of trust funds to those with a reasonable expectation of performing productive work activity.

- 96.4 percent of active cases and 96.4 percent of closed cases met the fourth SSC criterion which limits the use of trust funds to those with a reasonable, predictable period of productive work activity of sufficient duration to be cost effective to the trust funds.

- 98.2 percent of active cases and 97.9 percent of closed cases have a substantial, gainful activity, vocational objective at time of certification.

- 94.0 percent of closed cases received VR services that were significant to their rehabilitation.

- 78.4 percent of closed cases were earning at the SGA level or beyond at time of closure.

- In 91.3 percent of closed cases, a properly completed report of rehabilitation closure (SSA-853) was submitted to SSA.

- 73.5 percent of closed cases met all special selection criteria, received significant VR services, and earned SGA at closure.

Mr. Patek is a Vocational Rehabilitation Program Specialist, Social Security Rehabilitation Branch, RSA.

PUBLICATIONS & FILMS

International Aspects of Rehabilitation: Policy Guidance For The 1980s. Leonard G. Perlman, Ed.D., editor. Switzer Memorial Fund c/o National Rehabilitation Association, 633 S. Washington Street, Alexandria, Virginia 22314. 83 pages. \$5.

The monograph contains the proceedings and recommendations of the 5th Annual Switzer Memorial Seminar. Five chapters focus on such areas as institutions for disability prevention and rehabilitation, assurances of necessary services and support systems, disabled people attaining full societal integration, and dissemination of information.

Also included are recommendations, implications for action, and comments by international experts.

The seminar was hosted by the World Rehabilitation Fund in New York City in the Fall of 1980. Twenty five experts from various organizations, representing public and private sectors, participated in this memorial to the late Mary E. Switzer and as a contribution to the International Year of Disabled Persons. The monograph contains a foreword by Howard A. Rusk, M.D., President, World Rehabilitation Fund and Distinguished Professor, New York University.

Expressive Therapy. A Creative Arts Approach to Depth-Oriented Treatment. Arthur Robbins. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. \$22.95

This work explores the application of dance, art and music, and the psychological principles of creativity to depth-oriented therapy. The book presents the concept and technique of play as it applies to object relations

theory and the development of ego and self. The process of nonverbal expression and its relationship to verbal therapy is also examined in detail.

Locating, Recruiting, And Hiring the Disabled. Tami Rabby. Pilot Industries, Inc., 347 Fifth Avenue, New York, New York 10016. 63 pages. \$3.95.

As given on page 7 of the book: "This book examines the reasons for the current shortage in the supply of qualified disabled candidates and offers innovative approaches to locating, recruiting and hiring people with disabilities."

In pursuing its objectives, the author offers sections on the changing perspective in events surrounding handicapped people and examines the need for a broader outreach effort.

Two chapters deal with the immediate and the long-term strategies that will pay off in recruiting handicapped people.

An extensive appendix gives various lists of resource organizations and agencies that relate to handicapping concerns.

On Their Way: The Courage Story. Courage Center Film Library, 3915 Golden Valley Road, Golden Valley, Minnesota 55422. Telephone 612 588-0811. 16 mm. 18 min.

Although this film depicts specifically the services provided by the Courage Center, its message is that of what any comprehensive facility can provide to disabled people. The film shows how therapeutic, recreational, vocational, and residential programs help people live more independent and richer lives.

Addressing The Psychological Needs Of People With Disabilities

Barbara Jones

Medical science has made tremendous advances in recent years in the treatment of people with disabilities. However, with all the progress that's been made in education, medicine, rehabilitation engineering, and other fields that deal with the physical aspects of disability, there has been very little attention given to the psychological impact of living with a disability. People with disabilities and those close to them have unique psychological needs which are going largely unmet in the treatment programs that exist today.

The Wright Institute for Graduate Studies in Berkeley, California has taken a major step toward correcting this situation. Beginning with the fall semester of 1981, the institute initiated a new Ph.D. program in health and rehabilitation psychology designed to provide professionals who will be working with people with disabilities with necessary insights into the psychological and social problems presented by their clients or patients.

The new Ph.D. program will be broken down into two basic components: a study of the clinical aspects of the psychology of disability and an examination of social policy and its effect on people with disabilities. Both components will include extensive field work and research, as well

as classroom instruction. The program is primarily aimed at psychologists, but is appropriate for other human service professionals who want to earn a doctorate in psychology.

In the clinical portion of the program, course work will be concentrated on the basics of psychology and medicine, including topics such as advanced personality theory, child development, and medical issues in disability. During the social policy segment of the program such subjects as social and cultural aspects of disability and legal aspects of disability and health will be explored. Throughout the entire program, students will be doing field work in various agencies in the community that serve people with disabilities.

Impetus for Wright's new Ph.D. program came from Dr. Hal Kirshbaum, who is now the planning and development officer for the program. He was formerly employed as head of the counseling program at the Center for Independent Living (CIL), the pioneer nonresident support facility for people with disabilities in Berkeley. In his work at CIL, Hal found daily validation of his belief that the unique psychological needs of people with disabilities were not being met—even by psychologists and psychiatrists.

Hal's own experience as a person with multiple sclerosis as well as that with the people he served at CIL showed that health and rehabilitation professionals were not trained to deal with the profound psychological effect a disability can have on a person. They did not have an understanding of the deep sense of loss that is always felt by a person with a disability or the feeling of being excluded from some of life's experiences. These professionals also often overlooked the difficulty of coping with the attitudes of those who see people with disabilities as "abnormal" or "incomplete" people. And they needed to adjust their own attitudes to move away from a tendency to "take care" of their clients and patients and overprotecting them, which often robbed them of their ability to raise their self-esteem.

As a teacher, Dr. Kirshbaum had introduced and taught courses in the psychology of disability at Antioch College West in San Francisco at the masters' level. However, he felt that more extensive training was needed and that it should take place at the doctoral level since that was where the most critical professionals would be receiving their training.

He approached the Wright Institute with his idea for a doctoral program 21

in health and rehabilitation psychology and found officials there to be very receptive to the plan. The Wright Institute was chosen because of its reputation as a school that is not only open to innovative approaches but also has a proven track record for sensitivity to "minority" issues. They had previously established graduate programs dealing with special problems of women and racial minorities, and had an understanding of the fact that differences between various segments of the population called for different approaches and solutions.

The institute was founded in 1969 with the purpose of developing and applying psychological knowledge to issues of importance in our society. Its activities and programs are guided by a philosophy that stresses individual development and social action research; that is, research oriented toward participatory problem solving rather than simply the study of problems. Course work at Wright uses an interdisciplinary approach, interfacing the influences of sociological, legal and other disciplines with its programs in psychology.

The new Ph.D. program in health and rehabilitation psychology was officially inaugurated last May at a special fund raising dinner given in honor of Edward V. Roberts, Director of the California Department of Rehabilitation. Over 300 participants contributed \$125 each to attend the dinner to raise funds for scholarships in the new program. In addition, the Wright Institute conferred an honorary Doctorate of Humane Letters on Roberts for his long record of distinguished work on behalf of people with disabilities.

Ed Roberts is a familiar figure to those who work to further the interests of people with disabilities. He has spent all of his adult life working



Edward V. Roberst, Director of the California State Department of Rehabilitation was presented with an honorary Doctorate in Humane Letters by Dr. Philburn Ratoosh, President of the Wright Institute for Graduate Studies in recognition of his many years of service to people with disabilities.

so often keep people with disabilities out of society's mainstream. A respiratory quadriplegic, Roberts was refused admission as an undergraduate to the University of California at Berkeley in 1962 as being too disabled to pursue an education there. He responded by working with other students with disabilities to start a program that allowed them to attend classes while living in rooms at the campus hospital.

Having successfully broken through the attitudinal barriers that had kept people with severe disabilities out of the university, Roberts and his group turned their attention to the Berkeley community. They felt that if some basic support could be provided, there was no reason why students and others with disabilities couldn't live outside the hospital. The mechanism they created for providing that support was the Center for Independ-

ent Living, the first community based, consumer operated resource for people with disabilities of its kind. CIL provided peer counseling, help with locating housing or attendants, and similar types of support and assistance that made the difference between dependence and self-sufficiency for many people.

After leaving UC Berkeley in 1966 with an M.A. with distinction in political science, and his course work and examinations completed for his Ph.D., Roberts turned his attention to the education of others. He not only taught college courses, but became known as an innovator in developing new teaching methods and curricula. He also remained active in CIL and a wide range of other activities, including serving on the statewide advisory committee to the Department of Rehabilitation, the Board of Trustees for the United Bay Area Crusade (United Way), and Chairperson of the Disabled and Blind Action Committee of California. He served as Executive Director of CIL from 1973 until his appointment as Director of the State Department of Rehabilitation by Governor Edmund G. Brown Jr. in 1975.

Roberts is deeply involved in the new Ph.D. program in health and rehabilitation psychology at the Wright Institute because he sees it as having a potential for doing more than simply supplying a new generation of professionals with some needed academic skills.

Graduates of the Wright Institute program will come away with important insights into many issues that face people with disabilities, including the importance to all of us of living in an environment that is free of barriers to mobility; how the independent living movement has shown us that people with disabilities are ca-

(Continued on page 23.)

TOPIC OF STATE

Families Questioned On Community Placement

Ken Kjos, Center Director, Adult Achievement Center, Fergus Falls State Hospital (Minnesota), recently completed a survey aimed at determining whether families of the developmentally disabled on the State Regional Residential Center supported community placement alternatives for their relative or would rather have them remain at the center. The alternative care are group homes, usually a 6 to 12 bed family type setting or supervised apartment living situations in the community.

The recent out of court settlement (Welch-vs-Noot) which requires a reduction in the total state institution mentally retarded population motivated the survey. Currently there are 2,650 mentally retarded residents cared for in state institutions in

Minnesota. The court settlement would reduce that number to 1,850 by mid-1987. Under this plan and using the utilization rates for the catchment area of the Fergus Falls State Hospital, a maximum capacity of 117 developmentally disabled individuals could be cared for at the Fergus Falls State Hospital. This figure represents a 57 percent reduction of the current S.R.R.C. population and would mean that about 217 individuals would have to be discharged to community living situations.

According to the survey, 92 percent of the 225 parents, relatives or guardians who responded, are satisfied with the programing and care the hospital provides. Nearly eighty percent of those surveyed felt their relative is best served at the hospital and 16 percent feel their mentally retarded relative would benefit from a 6-12 bed group home.

The 225 individuals who responded to the survey totaled 83 percent of the 271 questioned. Approximately 68 percent of those surveyed feel their relative, upon reaching his or her greatest potential development would best be served at the hospital. The reason, most cited, was the quality of care available at the hospital. Twenty

seven percent stated that once their relative reaches his or her highest potential, they would prefer to see him or her go to a group home.

Eighty-four percent of the respondents were pleased with the interdisciplinary team process used at the hospital. The interdisciplinary team members, including doctors, social workers, teachers, parents and guardians and others who work with the resident, meet to discuss the individual resident's needs and goals.

Eighty-six percent of the parents and guardians said they would be dissatisfied or very dissatisfied if their relative were moved to another state institution outside this region.

The study concludes that the health care establishment in Minnesota should be aware of the potential for family conflict and crisis when placement into the community alternatives occurs. The move would be easier and less traumatic if families and the general public were made aware of the concept of a health care continuum and continuity for the mentally retarded, based on their own individual capabilities, needs and preferences.

—*The Weekly Pulse*, Fergus Falls State Hospital, Fergus Falls, Minnesota.

PHD PROGRAM (Continued from page 22.)

pable of self-sufficiency once attitudinal barriers that keep them out of employment, transportation, and housing are removed; and how society hurts only itself in denying the civil rights of people with disabilities. These graduates will be prepared to help in the development of a national policy that will address these issues and create solutions for the problems people with disabilities face today.

The program, through its research and field work, is also expected to develop new models for community

programs, as well as testing those that exist now for their relevance to the needs of their constituency.

Ed Roberts sees the goal of the disabled movement in the 80s as ensuring that there will not be another generation of "the handicapped." The new Ph.D. program at the Wright Institute is an important step toward realization of this goal.

Ms. Jones works in the Communications Office of the California Department of Rehabilitation.



Deaf Heritage: A Narrative History Of Deaf America

Edna Adler

A gift to the American deaf people by the National Association of the Deaf in observation of its 100th anniversary, *Deaf Heritage* recounts a history that is and should be of significance to everyone concerned with disabled people. A picture and narrative portrait of individuals, groups, events, acts as they comprise the body of a historical account, *Deaf Heritage* goes beyond its mission of presenting to the deaf people of America their own significant story. A colorful recording of happenings over a period of 168 years and of the individuals, deaf and hearing involved in them, has resulted in a book that is at once dedicated history and delightful literature.

Mr. Jack R. Gannon, Director of the Office of Alumni and Public Relations, Gallaudet College, is the author of *Deaf Heritage*. Deafened in early childhood, Mr. Gannon is himself part of the saga which he unfolds in his book. Employing the extensive archival resources of Gallaudet, a liberal arts college for deaf people, and numerous other information sources over the country, Mr. Gannon has put together a remarkably discrete history of the American deaf people.

Quite appropriately, Gallaudet College whose founder was the son of the first educator of deaf people in America, joined hands with the NAD in the important task of chronicling the history of Deaf America. The rich results of their joint efforts are dis-

played in the over five hundred pages of historical lore presented in *Deaf Heritage*.

The book begins as it ends on an educational note. At the beginning, there is the well-known story of the establishment in 1817 of the first permanent school for deaf in America. At the close, there is an impressive listing of known deaf Americans with earned doctoral degrees. In between these two mileposts in the annals of education of deaf people are a great many references and anecdotes concerning the institutions, their administration and staff that have carried education of deaf people to where it is today. It is noteworthy that among the founders of early schools for the deaf, a liberal number were deaf.

Deaf people, as a group, are often referred to as a cross-section of the general population. The deaf community described in the book does indeed replicate in microcosm the larger America. In their own time, deaf persons have reflected more or less the prevailing customs, interests and employment patterns of their fellow hearing citizens. What has set them apart and made them a distinct community is their mode of communication. The criticalness of sign language to the welfare of deaf people is well-told in *Deaf Heritage*. Deaf culture which is based on the artistic use of manual communication is referred to throughout the book. Team sports have always had a strong following in

deaf people and are discussed at length. As the author indicates, the complex local, state, regional, national sports and cultural activities that deaf people conduct regularly, underscore the importance of sign language to their social and emotional well-being.

That deafness is no deterrent to achievement and worldly success in the arts is evident in the number of featured stories offered on deaf painters, sculptors, illustrators, etchers, architects, stage and television performers, playwrights, and authors. In the business world, deaf individuals have excelled in the newspaper arts including editing, developing from early training at state schools for the deaf. The National Fraternal Society for the Deaf, an insurance firm, now in its eightieth year, and the National Association of the Deaf, a self-supporting voluntary organization, are exemplified in the book as ventures begun and operated entirely by deaf people. Emerging deaf physicians, lawyers, clinical psychologists, linguists, computer programmers, private consultants, and book publishers, to name a few of the newer occupations being pursued by deaf people, suggest that the 200th anniversary of the NAD will find a quite different Deaf America.

In *Deaf Heritage*, the National Association of the Deaf has left a rare legacy to every deaf man, woman, and child in America. The individuals and agencies that work with them have gained a resource unique in the professional literature.

Deaf Heritage is available through the National Association of the Deaf, 814 Thayer Avenue, Silver Spring, Maryland 20910. \$19.95 (paper)

Mrs. Adler is a Consultant, Deafness and Communications Disorders Office, RSA.

Language Used or Used Language?

Obfuscation is a term that defines the art of utilization of many big words on the pretext that these words are

At a recent training session, our instructor said: "I am tasked with the job of . . ." As *usaged*, the noun *stranged* our ear, so we *jobbed* ourselves with the task of finding out whether or not, as *noured*, the word could be verbalized, though we knew that many nouns had been *verbed* before, *i.e.*, walled, kissed, housed. In this case, we found the instructor correct, so we *desked* our investigation until we *memoried* an editorial called "English Blooming" in the *Washington Star* that *implicationed* and *sorrowed* Mr. Paul L. Bloom's use of not being interested in "Robin Hooding" when he "disbursed \$4 million in oil company overcharges to various charities."

The editorial commented that crime control might be called Wyatt Earping, and we might Stockmanize our family budgets. *Habited* thusly, the practice "may open the gates to linguistic shortcuts not yet imagined. . . . Explorers will go Marco Poloing, lawyers will Darrow in the courtroom and humorists will Thurberize. Amidst the short line drives now and then bounced against the mother tongue, this one has the potential of Babe Ruthing it."

An article by Mark Shields in the *Washington Post* (September 4, 1981) in writing about politicians, says, "If candidates expect civilians to have any respect for them or their positions, candidates must change

their language habits. They must stop talking in those noun-verbs. . . ." He gives an example of this: "Until you've heard a congressman describe Jimmy Carter's failure to 'dialogue' with the American people, you might not understand that new administrations have to 'staff up,' and, once they have, they can 'memo' everybody involved."

Truthing the matter, it is we who could be *shortcutted* by being *Englised* and *languageed* thusly. . . . (!)

Superabundance. Sue these words for nonsupport.

. . . *actively* seek—unadorned, seek reeks with activity!

. . . diamond sale *event* . . . A sale is an event and, evidently, the word "event" here presents a second event in which diamonds or other merchandise might be negotiable. . . .

Free gift. We have yet to pay for a gift, and we have intentions never to do so.

Elongationitisism. The simple form is preferred—throw rocks at ro-coco.

"Our task force met everyday this week for three hours." "This week, our task force met for three hours every day" says correctly what most people would indulgently accept from the first statement. But trouble comes from these kinds of constructions when the messages are more complex. If we train ourselves to be more precise with the uncomplicated, the

complex will tend to be clear, if not less complex.

Over the course of—in or during; on a widespread basis—widely; place of residence—home or residence; at the present time—now, at this time, presently; throughout the country—nationally.

Careful writing. Simple writing does not necessarily mean clear writing.

. . . "to provide *factual* data on the costs. . . ." Data that are "provided" are a fact. In fact, we wonder if this author was not thinking of such descriptives as "relevant" or "actual" or "accurate"? But if they were nonfactual, then, of course, state the fact factually with the factual data identified as nonfactual. . . . And that's a fact!

Bureaucratic Bias (good words that become vogue and, consequently, vague.) **Executive summaries:** You can't get away from it, a summary is an epitome no matter what epithet you precede it with. For mercy's sake, let a good word alone. Geez!

"They wish to make all of his decisions *for him*." "For him" is understood in "his decisions."

Pastiche. Grab bags are great in junk sales; they have no place in precise writing.

A friend contributed the following sentence gleaned from an editorial in a developmental disabilities newsletter: "If a person abandons his or her ability to be part of a team in dealing with the issue of community placement, then he or she has surrendered their right to act like a professional." Is this, indeed, a "surrender" to *à la mode* expression? We paraphrase: "If a person abandons his or her (or his/her) responsibilities to write clearly, then he or she and they or them are going to go right up the wall trying to get his or her or their (or his/her/their) message."

Computerized Placement Service

Roger S. Decker and Sander VanderWerf

The placement of qualified disabled job applicants in pursuit of employment is a difficult task. Although the role of placement has been with us since the inception of the National Civilian Rehabilitation Act of 1920¹ and has continued to be emphasized and expanded within the present rehabilitation legislation,² the rehabilitation community continues to be confronted with the issue of successful job placement. There have been suggestions for technicians to assist in the placement of the handicapped³ or for the expansion of professional expertise in the field of rehabilitation with the addition of placement specialists at the local/regional and state levels,⁴ to compensate for the limited time the counselor spends in placement,^{5,6} but no ready solution has been found for this problem.

As we look at the issues, we find job placement to be a multifaceted problem relating to the needs for a specific body of knowledge⁷ and for clearly defined techniques to perform a task which has a nebulous structure. Also, there seems to be lack of management control of this aspect of the rehabilitation process due to insufficient information systems to quantify and provide feedback on placement activities.

Vocational Rehabilitation Agency, the Emory University Research and Training center was funded to address one aspect of the placement process, that of increasing the efficiency and effectiveness of matching qualified disabled people with known job openings.

A meeting was held with a group of counselors to review their placement needs. The brain-storming session elicited a rather substantial list in which several significant areas stood out.

First, counselors reported that they did not have sufficient time to perform job placement and job development for the job-ready client. Whether or not this was a matter of poor time management on the part of the counselor or whether it was, indeed, a reality that time did not exist for him to perform this essential function was not taken into account at this time. The problem was reported as one of the major barriers to effective job placement.

The second issue which appeared in many of the needs statements was the lack of labor market information to assist in planning for and locating appropriate job openings.

Two other issues surfaced in statements of critical incidence by several of the participants. One incidence

was related to the problem of filling job openings with qualified handicapped people. Several counselors expressed concern that a job opening with a primary employer would be secured only to have the position turned back as unfilled because the agency was unable to quickly review its pool of job-ready clients to determine who might be qualified to fill the position. The second issue related to being able to take into account the limited physical capacities of qualified handicapped job applicants, as related to the physical requirements for a specific job. Individual counselors and placement specialists reported that, in many instances, they had located clients who initially appeared to be able to perform the job only to find that once at the work site he was unable to successfully perform the essential physical capacity activities required. This occurred because the job required specific physical activities beyond the usual job description that were not reported in the notice of job openings.

A review of the typical counselor approach to placement would suggest that he maintains his own labor market information files. These usually consist of either a formal or, more likely, an informal register of employers who have been contacted, and

possibly general information on jobs, contact persons, and reviews of entry level jobs. The files, if formal, would be developed to meet the needs of individual professional and might not include data which would be usable by or readily available to other professional staff members.

The usual procedure for processing a job opening which is secured by the individual counselor and/or placement specialist is for it to be held by the developer for the primary purpose of providing a placement for his job-ready clients. This limits the accessibility of the job opening to other counselors and their job-ready clients. This practice reduces the number of positions which would be available to job-ready handicapped people, nor does it meet the needs of participating employers.

A third problem is the formal identification of clients who are job-ready. This number will vary, depending upon the amount of paper work completed; and it may or may not identify all job applicants within the formal rehabilitation process system. Because of the paper work problem, these job-ready people cannot be reviewed against job openings which go unfilled by the rehabilitation system. If information on job-ready clients and job openings was gathered in a central location, the job matching could easily be completed.

In an endeavor to address as many of these problems as possible, the Emory University Research and Training Center surveyed the tools and resources which were available to assist in providing a solution. The review quickly brought to the staff's attention the need for a mechanism that would be fast, handle large amounts of information, and yet be able to be used with a minimal amount of paper work. With these criteria as a guide, the staff proposed the use of comput-

ers. The system used as its foundation the fourth edition of the *Dictionary of Occupational Titles*, which uses its nine-digit code system as the basis for matching jobs with job-ready clients. The process of matching jobs with qualified job applicants through the computer was accomplished. The rehabilitation client and counselor identified a vocational objective as defined by the *Dictionary of Occupational Titles* (DOT) with its corresponding code. The client's identified vocational objective was compared against the jobs which are also listed by DOT number within the system. A match of the nine-digit codes was requested. If these existed within the client bank and the job bank, the computer reported a match, with identifying information.

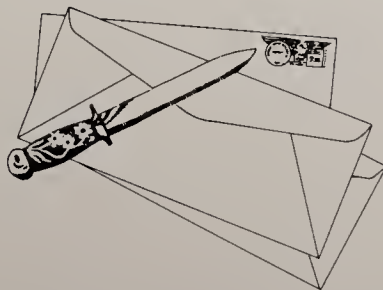
In reviewing the matching process, the project staff felt that greater variability in the job-client match could be provided if alternative comparisons were identified. Through trial and error, it was discovered that three additional matches could be accomplished. The second match would compare the first six digits of the DOT code for both client and job. This match provided the client with a position very similar to his or her identified vocational objective, although it would not be a "perfect" match. For example, if in the first match the vocational objective of the

client was bank teller, which has nine specific DOT digits, the computer on the second search might select the job of cashier, hospital, which would have the same first six DOT digits but not the latter three. This would provide a very similar job, but not the exact job requested.

A third match was found to be helpful to some clients who were interested in a specific occupational area, *e.g.*, agriculture, machine trades, sales, etc., rather than in a specific job. This area of interest was resolved through a search of the first three digits of the DOT code. This would allow for some expansion of the original career choice and might allow the person and his counselor to become aware of jobs which existed within a particular field of work which were readily available, and might be as suitable as the original vocational selection. It would, however, require an adjustment in the vocational objective, but hopefully would result in a successful placement.

The final match was based on the Worker Trait Characteristics. This match was developed on the premise that, if an individual had specific worker traits, these would be transferable across occupational classifications. The project found a substantial amount of variability in worker traits matches. These matches did, however, provide expanded labor market information and career choice areas for the job seeker.

The computerized job match system provides a number of benefits, the first of which is that it operates very rapidly. The system can compare a client's job selection with all the possibilities within the job bank system in a matter of seconds or less. The system which was established would allow the project to match all job-ready clients with all jobs in the

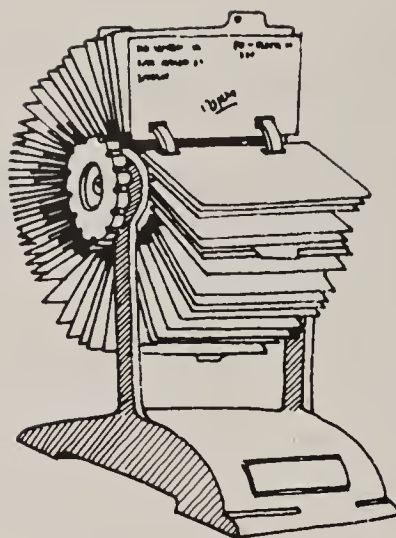


system within a 30-minute period. After the half-hour match period, the system was ready to report back to counselors all job matches which were found. This is in comparison to the individual process where the rehabilitation professional would review client information and match it with each job within his own personal job bank system, and/or check it out with any jobs which were being held by other professionals within his office or region. The computerized system greatly reduces the time involved and can increase the number of job/client matches.

An additional benefit to the counselor, beyond the speed with which jobs can be matched, was also discovered. Once a job is placed within the system and a client is found to match the job, the counselor and/or the job-ready person can respond to the employer within 1- to 4-hours, thus enhancing the opportunity for securing the job rather than having it filled by another job applicant.

Second, the system provides expanded labor market information for the counselor and the job-ready client. Not only do they have an understanding of those businesses and industries with which they make personal contact, but the counselors also have the benefit of the contacts made by other rehabilitation professionals and the employment information reported into the system. This expanded labor market information hopefully will enhance the speed and quality of the rehabilitation placement.

The third benefit is its ability to provide labor market information from which the counselor can draw labor market trends. Through this process, the counselor can review the types of jobs which are being placed within the system over a period, and he can determine the types of jobs that seem to be more readily available



within a specific labor market area. This information will assist rehabilitation professionals to make job selections which will be aligned with growing labor market areas.

A fourth benefit will assist the counselor in preplanning, such as in vocational training. The system has been developed to allow the identification of people who are in training and will soon be ready for employment. Information can be provided to placement specialists on those people who are completing training. The specialists then can assist them in planning their job development activities.

A final benefit of the computerized system is its ability to provide feedback information—Who has been placed within the system? What kinds of jobs have been developed? What specific professionals have been doing to interact with the system? This information could be used to assist in the verification of job development and placement activities of rehabilitation professionals.

The Computerized Job Placement System was developed with the assistance of the Georgia Division of Vocational Rehabilitation. Although it has not been fully developed, due

to reduced funding, it was found to have a significant amount of benefit in assisting in expeditiously matching clients with jobs within a specific labor market. It is fast, provides expanded labor market information, and assists in allowing professionals to focus their attention and counseling activities to meet the changing demands of business and industry.

Mr. Decker is Assistant Professor, Department of Rehabilitation Medicine, Emory University School of Medicine, and Director of Training, Emory University Regional Rehabilitation Research and Training Center. He served as project director of the project described. Ms. Vander Werf was a research associate for the Research and Training Center and also served as project coordinator.

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- 2) Public Law 112, 93rd Congress, 1973.
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- 6) Emener, W.E. and Rubin, S.E. Rehabilitation counselor roles and functions and sources of role strain. *Journal of Applied Rehabilitation Counseling*, 11(2), 57-69, 1980.
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NEWS, NOTES, ANNOUNCEMENTS



At the NRS-NIMH press conference, from left to right, are: Jean Tufts, U.S. Department of Education; Dr. Herbert Pardes, Director of the NIMH; Virginia Knauer, Special Assistant to the President; and Walter Conti, Chairman of the National Restaurant Association.

Restaurant Assn. Promotes Hiring Mentally Restored

Noting that the National Restaurant Association "is committed to the hiring of the handicapped and the mentally restored," NRA Chairman Walter Conti announced at a recent press conference that the NRA and the National Institute of Mental Health (NIMH) have begun a joint effort to promote the employment of the mentally restored in the foodservice industry.

At the press conference, Conti and Dr. Herbert Pardes, Director of the NIMH, joined by Virginia Knauer, Special Assistant to the President, presented the results from a study that surveyed the employment practices of the foodservice industry regarding the handicapped, mentally retarded, and

mentally restored. The survey was the first of its kind for any industry.

"Our industry offers a great opportunity for handicapped people" Conti said. "40,000 participants have been placed in the foodservice industry as a result of various programs throughout the country. These individuals are loyal, dedicated workers. As a group they have a low absentee rate and get the job done."

The survey of the foodservice industry was a joint project of the NRA and NIMH. Among the findings:

- Forty-eight percent of the respondents reported they had employed the mentally retarded, and 46 percent had employed physically handicapped workers.
- Twenty-nine percent had employed mentally or emotionally restored workers.
- Mentally restored workers are described as better than their coworkers in job attendance, and at least

equal when it comes to quality of work, motivation, and job tenure.

- Most respondents employ mentally restored workers in the sanitation and food preparation areas.

- Fellow employees of the mentally restored are described by their employers as having positive attitudes toward the mentally restored workers.

- Among respondents who had not hired physically handicapped, mentally retarded, or mentally restored personnel, willingness to do so in the future was high.

Nearly 8,000 questionnaires were mailed to NRA members, and completed surveys were received from 1,426. A copy of the report is available from: Director of Human Resources Walter Ashcraft, National Restaurant Association, 311 First St., N.W., Washington, D.C. 20001.

Baltimore To Host Careers Symposium

The National Careers for the Disabled Symposium, offering first-hand information to career-oriented disabled people, will be sponsored by Commodore Business Machines, Inc., in association with Careers for Disabled, Inc., and be held at the Convention Center in Baltimore, Md., December 4-6.

The symposium will reach out to the many thousands of people who, because of their disabilities, and in some cases lack of skills, have been kept out of the mainstream of the work force.

Each workshop will include a special lecture on "how to" obtain training and then market new or existing skills in areas such as computer technology, starting your own business, continuing your education, sales, government and unions, finance, 29

printing and graphic arts, clerical, travel and leisure, food services, communications, and repair trades.

Additional information and reservation forms for the National Careers for the Disabled Symposium are available by contacting Careers for the Disabled, 261 Madison Avenue, Suite 1102, New York, New York 10016.

Courage Award Presented To Max Cleland

Max Cleland, former head of the Veteran's Administration, has won the second annual National Courage Award, presented by Courage Center in the Minneapolis suburb of Golden Valley.

The National Courage Award honors people who have made a significant impact on a regional or national level in improving attitudes toward and services provided to physically disabled people. The award is a 15-inch replica of a bronze, winged figure, "Spirit of Courage," by Minnesota sculptor Paul Granlund, which stands outside the lobby of Courage Center.

Cleland is himself disabled, a triple amputee as the result of a grenade explosion while he was serving as an Army paratrooper captain in Vietnam in 1968. Undaunted by his disability, he returned home to Georgia and, beginning in 1970, served two terms in the Georgia State Senate.

President Jimmy Carter appointed him Administrator of the Veterans Administration in 1977. During his term, Cleland strove to make the VA more responsive to the needs of Vietnam veterans and sought to develop younger VA management personnel through the Leadership VA program. Said President Carter during



come the handicap of disabilities suffered in a way that never demanded sympathy . . . he manages his own affairs. He never asks for special consideration. He is a strong and forceful leader."

Cleland now tours the country lecturing about his past experiences and discussing issues affecting people with physical disabilities. He was honored at a public ceremony at Courage Center along with the winners of the 1981 Rose and Jay Phillips Awards, presented annually to five men and women who have achieved outstanding success in their vocations despite severe disabilities.

Recertification Course

Rehabilitation counselors may now meet the 5-year recertification requirements of the Council on Rehabilitation Counselor Certification (CRCC) by completing three of five new home-study courses offered by the University of Wisconsin-Extension.

The courses include: Rehabilitation Perspectives (A500); Rehabilitation Community Resources (A501); Rehabilitation Client Assessment (A502); Rehabilitation Counseling Approaches (A503); and Rehabilitation Placement Methods (A504).

The textbook for all five courses is *Total Rehabilitation*, a five-part volume published by Little, Brown of Boston in 1980 and written by George N. Wright, Ph.D. CRC, and Professor of Rehabilitation Counselor Education at the University of Wisconsin-Madison. Prof. Wright also designed the five correspondence courses and wrote the study guides. The course work is jointly approved by the UW-RCE program and UW-Extension.

The cost of each course is \$62. This fee includes the study guide and instruction. The text can be purchased for \$32.50. It can serve as a handbook after completing the course work; it has 830 pages with over 5,500 subject citations in the index, including technological definitions from glossaries in the 40 chapters.

For an application to enroll, write to: Independent Study, UW-Extension, 432 N. Lake St., Madison, WI 53706.

Course Available For Blind Diabetics

The Hadley School for the Blind has announced a new course—*You, Your Eyes, and Your Diabetes*. The course assists people who have sight impairment due to diabetes.

The relatively short course consists of six lessons. Topics include: facts about diabetes; administration of insulin; preparations of diabetic diets; everyday living skills; prevention of other complications; personal and social attitudes about blindness; and resources for the blind diabetic.

To enroll, write or call the Hadley School for the Blind, 700 Elm Street, Winnetka, Illinois 60093. Call toll-free, 1-800-323-4238 during business hours (8 a.m. to 4 p.m.) Central Time.

Library Develops Solar Panels For Use In Remote Areas

A reader's request for braille magazines was the origin of solar panels for charging cassette batteries, an accessory currently being produced for patrons in areas without electricity. Trapping solar power and braille magazines are not directly connected. The link in this case is that both met the needs of a particular patron.

The Inspiration

Jan Little, an American citizen living abroad, wrote in July 1979 for reading material such as braille magazines that did not need to be returned. The address was Cucui, Amazonas, Brazil, but she described her real location as "about a hundred dugout-canoe miles from Cucui" and added that foreign packages to Cucui go through the customs house in Manaus, still another thousand miles away. Because of the distances and the difficulties, she received mail deliveries only three times a year, and then only by courtesy of the Brazilian Air Force for the Manaus-to-Cucui leg of the journey. Receiving material was hard; returning it impossible.

She added that she would like to have recorded material, but that it wasn't possible because there was no electricity and no way to recharge batteries.

The NLS Materials Development Division thought that it was possible. They responded to the challenge by making a panel consisting of small

silicon solar cells linked together that can operate the machine in direct sunlight or recharge batteries for use at other times. The standard cassette player was modified with a jack to accept the solar-powered source.

The light-weight, heavy-duty panel developed was a low-cost project that did not involve new technology. Instead it adapted materials available commercially for the special needs of a patron in a location where reading materials were scarce and precious.

NLS sent braille magazines immediately and wrote Ms. Little about the panel and to request instructions for the best way to insure delivery of it and the adapted cassette machine.

Use By Other Patrons

Meanwhile, responding to the needs of one patron raised the question of whether there might be more patrons who could use such a device. An article in *News* (March-April 1980) about Ms. Little's situation and the solar panel provoked requests from patrons and ideas from network librarians about how these panels could be used.

One of the first patrons to state an urgent need was a Peace Corps volunteer working with a school for blind individuals in Africa, also in a region without electricity. The Alaska regional librarian expressed an interest for patrons in isolated locations. Idaho serves several Indian reserva-

tions and has patrons who live in wilderness areas. Other librarians mentioned requests from campers.

As a result, about 200 solar panels are now being produced for the NLS program by Gauthier Industries in Rochester, Minnesota. They will be available through cooperating libraries for long-term loan to people living in remote areas and for short-term use for campers and others going into places without electricity.

That First Solar Panel

The original solar panel never made its proposed canoe trip up the Amazon and what Ms. Little had said about problems with the mail was verified. Ms. Little returned to the U.S. in October 1980 and did not receive NLS's letter about the panel, forwarded from the American embassy in Brazil, until six months later.

Her immediate reply, dated April 4, 1981, reads in part: "This offer impresses me as remarkable both in engineering and in concern for those receiving the library service . . . I hope that this effort made on my behalf will benefit someone else as interested as I . . . At least I prompted, unknowingly, some attention and a practical step to what some day should be in common use."

Ms Little confirmed the need in a recent telephone conversation to let her know that others were going to benefit from what she had inspired. "No one knows," she said, "what it means to be without electricity until they've experienced it. I could cope with cooking and all the other things, but I found it very hard to be without books."

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REPORT RESOURCES

INTERPRETER SERVICES FOR DEAF CLIENTS: GUIDELINES FOR REHABILITATION PERSONNEL. Seventh institute on rehabilitation issues. Research and Training Center, University of Wisconsin, Stout Vocational Rehabilitation Institute, Menomonie, Wisconsin 54751.

PROGRAM EVALUATION IN VOCATIONAL REHABILITATION: OBSERVATIONS. U.S. Department of Education, Office of Special Education and Rehabilitative Services, Rehabilitation Services Administration, 330 C Street N.W., Washington, D.C. 20202.

THE ECONOMICS OF DISABILITY: INTERNATIONAL PERSPECTIVES. Rehabilitation International, 432 Park Avenue South, New York, N.Y. 10016.

STILL A WOMAN, STILL A MAN. A slide-tape presentation on the sexual and relationship concerns of people with disabilities. Elliott Bay Associates, 2366 Eastlake Ave. E., Seattle Washington 98112. \$200.

SPEECH ASSESSMENT AND SPEECH IMPROVEMENT FOR THE HEARING IMPAIRED. Information Services, Alexander Graham Bell Association for the Deaf, Inc., 3417 Volta Place N.W., Washington, D.C. 20007. \$19.95.

REHABILITATING PEOPLE WITH DISABILITIES INTO THE MAINSTREAM OF SOCIETY. Allen D. Spiegel, Ph.D., and Simon Podair, editors. Noyes Medical Publications, Mill Road at Grand Avenue, Park Ridge, New Jersey 07656. \$28.

ACCESSIBILITY AUDIT FOR CHURCHES. Service Center, General Board of Global Ministries, 7820 Reading Road, Cincinnati, Ohio 45237. \$2.

IMPLEMENTATION OF INDEPENDENT LIVING PROGRAMS IN REHABILITATION. Seventh Institute on Rehabilitation Issues. Arkansas Rehabilitation Research and Training Center, University of Arkansas, Hot Springs Rehabilitation Center, Hot Springs, Arkansas.

CONGRESS AND HEALTH. An Introduction to the legislative process and its key participants. National Health Council, Inc., 70 West 40th Street, New York, N.Y. 10018.

GLOSSARY. Vocational rehabilitation and the employment of the disabled. International Labour Office, International Labour Organization, Geneva, Switzerland. 15 Swiss francs.

THE SOURCE BOOK FOR THE DISABLED. A special book—the first illustrated guide to easier, more independent living for physically disabled people, their families and friends. Glorya Hale, editor. Bantam Books. \$3.95

EMPLOYMENT OF HANDICAPPED INDIVIDUALS. Including disabled veterans in the Federal Government. U.S. Equal Employment Opportunity Commission, Washington, D.C. 20506.

COPING WITH ALZHEIMER'S DISEASE: A GROWING CONCERN. Ann and Stephen Newroth.

National Institute on Mental Retardation, 4700 Keele Street, Downsview, Toronto, Ontario, Canada M3J 1P3. \$3.

BRAILLE BOOK REVIEW. CMCA-CMLS, P.O. Box 8560, Capitol Heights, Maryland 20027. A bi-monthly publication distributed free to blind and physically handicapped people who participate in the Library of Congress free reading program.

CONTINUING EDUCATION OUTREACH PROGRAM FOR DISABLED ADULTS. Continuing Education Outreach Program, Community Service and Continuing Education Branch, Office of Postsecondary Education, U.S. Department of Education, Washington, D.C. 20202.

REPORT TO THE PRESIDENT. MENTAL RETARDATION: PREVENTION STRATEGIES THAT WORK. Publication number OHDS 80-21029. U.S. Department of Health and Human Services, Office of Human Development Services, President's Committee on Mental Retardation, Washington, D.C. 20201.

FAMILY AND CHILD MENTAL HEALTH JOURNAL. Biannual. Human Sciences Press, 72 Fifth Avenue, New York, N.Y. 10011. \$12 per year.

AMERICAN JOURNAL OF CLINICAL BIOFEEDBACK. Biannual. Human Sciences Press, 72 Fifth Avenue, New York, N.Y. 10011. \$12 per year.

MAINSTREET. Community Action for Disabled Americans. A Guide for Service Organizations. The President's Committee on Employment of the Handicapped, Washington, D. C. 20210.

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page
4

Notice To Our Subscribers

Along with all the other branches and units of government, *American Rehabilitation* is subject to fiscal reductions. A continuation of publication request has been submitted to the Office of Management and Budget (OMB). As of this writing, the authority has not been granted. Therefore, publication will be held in abeyance until definitive instructions are received from OMB.

The editor will continue the solicitation of manuscripts and the review of unsolicited scripts for potential use in a possible consolidated publication within the Department of Education. Should permission be granted, the regular numbers of the magazine will be resumed; should it not, subscribers will be so notified.

AMERICAN REHABILITATION

Volume 7, No. 4 The weakest ink is better than the strongest memory. **March-April 1982**

-
- | | | |
|----------|---|----------------------|
| 4 | Handicapped By Design: The Need For Printing And Publishing Guidelines | Jack B. Ralph |
|----------|---|----------------------|
-
- | | | |
|-----------|------------------------------------|-------------------|
| 15 | Review: A Rose For Tomorrow | Edna Adler |
|-----------|------------------------------------|-------------------|
-
- | | | |
|-----------|--|-----------------------|
| 18 | New Concepts And Directions In Rehabilitation | George A. Conn |
|-----------|--|-----------------------|
-
- | | | |
|-----------|---|---|
| 21 | New Wave In Rehabilitation: Projects With Industry | James T. Magee, Thomas J. Fleming, and James Geletka |
|-----------|---|---|
-
- | | | |
|-----------|---|----------------------------|
| 25 | Blind Beep Baller Belt "Burners" | Dallas Bellamy, J02 |
|-----------|---|----------------------------|
-
- | | | |
|-----------|--|----------------------|
| 28 | Work Program Pays Big Dividends | Marge Sanders |
|-----------|--|----------------------|
-
- | | | |
|-----------|---|--|
| 30 | Self-Actualization of Rehabilitation Counseling Students: Pre and Post Comparisons | Bobbie J. Atkins, Ph.D., Ann B. Meyer, Ph.D., and Christopher I. Stone, Ph.D. |
|-----------|---|--|
-

DEPARTMENTS

- | | | | |
|-----------|-------------------------|-----------|-----------------------------------|
| 2 | Topic of State | 16 | Notes On The Margin |
| 13 | Report Resources | 20 | New Publications |
| 14 | Language Used | 26 | News, Notes, Announcements |

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TOPIC OF STATE

Innovative Student Aids His Classmate

(The following was submitted by Wayne Zoutendam, Counselor with the Wausau Wisconsin DVR Office).

Robert Dampier, a senior at Lincoln High School in Wisconsin Rapids, could be considered a rehab engineer in the making. Bob is a friend and neighbor of a fellow student who is rapidly losing his vision and is being served by the Wausau VR office. The friend has diabetes and requires constant monitoring of urine for sugar content. To promote his independence in this respect he has been provided with an electronic urine tester by Science for the Blind of Wayne, Pennsylvania.

It was hoped to achieve independence in insulin measurement with the provision of a dose-aid insulin measuring device. However, because of the varying doses of insulin required, it was necessary to prepare some type of spacer which could be inserted to achieve different dosages by stopping the syringe plunger at a specific point to obtain a specific dose.

Here, Bob's creativity came into play. He felt that best material to use for the needed spacers would be plastic. Brian's father works at a plastics manufacturing firm and obtained the needed materials. Bob very carefully and precisely fabricated the spaces for his friend to use. They are now being marked in braille for identification purposes.

This contribution by Bob, states Zoutendam, is probably only the "tip of the iceberg." Bob has been an inspiration to his friend in many ways.

He has learned braille with his friend to help and encourage him. After graduation from Lincoln High School this year, Bob hopes to enroll in an electronics program at NCTI. Zoutendam states that Bob knows what hard work is all about. He has come through the ranks of the Boy Scouts and serves as a junior counselor in that program. In addition, Bob has added to limited family finances by part-time jobs including farm work. At this time, the only obstacle standing in the way of his enrollment to NCTI is lack of finances. Bob hopes to receive financial aid in order to pursue his life goal of electronics. Meanwhile, his friend plans on completing his senior year at the high school with indefinite future plans.

—Wisconsin DVR Newsletter.

Mass. VR Leader Receives Honors

Elmer C. Bartels, head of the Massachusetts Rehabilitation Commission, received an honorary Doctor of Humane Letters degree from Boston University in a special convocation celebrating the centennial anniversary of the University's Sargent College of Allied Health Professions.

Founded in 1881 by physician Dudley Allen Sargent, Sargent College is dedicated to educating health professionals to prevent disease and restore optimal function to the disabled. Reaffirming its purpose, Sargent College will honor Bartels for his significant contributions to the field of rehabilitation.

Bartels has been Commissioner of Rehabilitation in Massachusetts since 1977. Before this appointment, he pursued a career in computer software development. He spent 9 years with the information systems department at

the Honeywell Corp., first as a senior systems analyst and then as department manager. Bartels has published extensively both in the field of computer science and physical rehabilitation.

Paralyzed by a spinal cord injury, Bartels has been a leader in the development of consumer and service organizations for the disabled in New England. He helped establish the Massachusetts Association of Paraplegics and was instrumental in the creation of the New England Spinal Cord Injury Foundation. Bartels has also improved the quality of life for the disabled through his active involvement with the Boston Center for Independent Living.

First Awareness Merit Badge Awarded

In the November 1980 newsletter, we reported that the Boy Scouts of America had established a new merit badge for "handicapped awareness." On June 12, the first such award was given to Todd Kelly, a 14-year-old scout from Culver City (Calif.).

Requirements for the Handicapped Awareness Merit badge included learning about resources available to people with disabilities, participating in an awareness program, and spending 15 hours working with people with disabilities. Todd Kelly fulfilled the requirements and then some, putting in 17 hours of official volunteer work at the Jeffrey Foundation, a center serving young people with severe disabilities between the ages of 2 and 21. He also volunteered in a special evening program for adults with disabilities in West Los Angeles.

Todd's experience demonstrates the potential of increasing the awareness of young people to disability is-

sues. The work he did in earning his merit badge impressed him so much that he is considering an Eagle Scout project that will raise funds for installing wheelchair ramps at Camp Josepho in the Santa Monica mountains. If others follow in Todd's footsteps, the seed planted by the Boy Scouts of America could grow and multiply into a significant gain in understanding and overcoming problems faced by people with disabilities in America.

—*Rehab Review*, California Department of Rehabilitation.

Early Counseling Makes Big Difference

Early vocational counseling may mean the difference between work and unemployment for persons who receive disabling injuries, according to a University of Wisconsin study.

Dr. Richard Harvey, chairman of the Department of Rehabilitation Medicine at UW Hospital and Medical School, and Hollis Jellinek, rehabilitation psychologist, studied 86 patients with severe head and spinal cord injuries over a 2-year period. Half of the patients received vocational/educational counseling while in the hospital; the other half were hospitalized before the hospital developed the counseling program.

About 75 percent of those who received counseling in the hospital were employed 3 years later, compared to 19 percent of those who received no onsite counseling.

Vocational/educational counselors visited patients during the first week of hospitalization and throughout the rehabilitation process. Patients were taught to incorporate their disability into their old jobs or they were taught

new skills. Instead of settling into a mindset of being disabled, patients were encouraged to function independently as students or workers.

Other studies have found that 33 to 62 percent of persons with spinal cord injuries were working or in school 3 years after their injury. These studies have demonstrated a link between successful employment and previous educational and vocational levels, in addition to age and sex of the patient. However, the UW study is the first to measure the effect of onsite counseling.

"Rehabilitation patients have been shown to benefit from a program that provides more than expert medical care," say the authors. "Effects of the total rehabilitation process have been major factors related to favorable experience of 'successfully' disabled persons."

Results of the study will be published later this year in the *Archives of Physical Medicine and Rehabilitation*.

—*Wisconsin DVR Newsletter*.

Survey Pinpoints Future Job Areas

A survey which was recently conducted in Lucas and Wood counties (Ohio) will benefit clients of the Rehabilitation Services Commission, Ohio taxpayers, and companies and industries in that area.

The survey, cosponsored by the National Alliance of Business (NAB), the Council on Vocational Rehabilitation of Toledo (along with the Toledo Chamber of Commerce and the Toledo Area CETA Consortium), pinpoints specific job areas from now until 1985. Conducted by the Univer-

sity of Toledo Management Center, the data will provide Toledo area RSC counselors with the information to direct a client into the type of job-training program he or she needs for the Lucas-Wood County area. The ultimate result will be: (1) companies and industries with workers skilled to the counties' needs; (2) savings in time and money for both RCS and its Toledo area clients; and (3) lessening of the taxpayer's burden by enabling an RSC client to become a taxpaying citizen in a shorter period.

In polling 2,000 private sector firms concerning their manpower needs, the labor market survey revealed a total of 20,220 jobs that will be needed over the next 5 years. The positions in highest demand through 1985 are nurses, food service workers, office clerks, waiters/waitresses, and general laborers.

George Sarantou, RCS Toledo area job development coordinator and counselor, is pleased with the results of the survey. "We are already implementing the results," said Sarantou, who is a member of the sponsoring committee. "Each office has a copy, and staff members are presently studying the data."

"The benefits from this project are truly measurable. In fact, as a direct result of the survey, CETA is spearheading a training program for the Toledo banks. Within the next 30 to 60 days, we hope to enroll clients in the NAB/CETA program, specifically to train them in the area of bank telling."

"One of the most important benefits from the survey is the line of communication that has developed between rehabilitation and industry. We look forward to further strengthening our relationship with the business community of Toledo through the National Alliance of Business."

—*Ohio RSC News and Views*.

Handicapped By Design:

The Need for Printing and Publishing Guidelines

Jack B. Ralph

Editor's Note: The following article runs much longer than those ordinarily printed in *American Rehabilitation*. The material, however, presents important information in the area of printing and publishing which should be of vital interest to all of our constituency, especially so in these days of cost consciousness.

Because of the extensive annotation in this article, we have preserved the author's style.

A note that will become more obvious as you read this article: *American Rehabilitation* is printed in 10/12 Times Roman (a serif type), with annotations printed in the same size, but with captions printed in italics. Column width is 13½ picas, 28 picas, and 42 picas. The table of content (page 1) is printed in 12 point helvetica bold (a sans-serif type).

Millions of people live a visually handicapped life because of the use by printers and publishers of ill-considered design specifications. This results in federal, state, county, and local governments not getting their money's worth with the materials they publish. The printed information and guidance are not being read by millions of constituents, because reading the material is really hard work and often a visual impossibility.

It is necessary, from a cost effective basis, as well as from a civil rights basis,⁵⁰ to develop and implement printing and publishing guidelines to accommodate people with limited visual ability and limited reading skills.

It is difficult to count the exact number of people with visual problems because of overlapping visual conditions that result in counting the conditions two or more times;^{1,2,3} some uncertain diagnoses of the conditions;^{1,2} problems of how to count temporary visual problems;^{1,2} incorrect design and administration of surveys; the use of improper techniques in the selection and administration of certain visual acuity and color vision tests, producing incorrect results;^{2,3,4} vanity on the part of visually limited people in refusing to admit to a handicap;^{38,40,42} and, in some cases, some visually limited people may not realize that they are supposed to see better.

Likewise, it is difficult to count the people who have difficulty in reading and understanding.

There are, however, some estimates good enough to provide a general idea of the need for guidelines:

- 500,000 people are seriously visually limited, and need mechanical apparatus to read "regular" size

print.^{5,6,28,29,33} 1,000,000 people are severely visually impaired and cannot read ordinary newsprint with glasses.^{5,6,28,29,33}

- An additional 10,500,000 people are visually impaired and cannot read small size print and printed materials in certain colors of ink and paper.⁷ The loss of vision with age^{43,46} and the resulting decline in near vision is caused by increased yellowing of the lens, retinal disorders, myopia, corneal or scleral problems, multiple affections, refractive errors with lesser disability, increasing clouding of the vitreous (eye fluid) with age, and other known and unknown conditions.^{3,5,6,9,28,29}

- 14,000,000 deaf and hard of hearing people use their eyes every day for reading sign and/or lips in addition to their regular reading.⁸ By the end of the day, they would seem to have no energy and desire to read print and colors that would be difficult to see.

- It is estimated that 20,000,000 people wear spectacles and contact lenses that have prescriptions no longer suited to them.⁹

- It is estimated that 20,000,000 people have need of some visual correction but do not know it.⁹

- 8,500,000 men and 650,000 women are color deficient ("color

blind"). They rate special consideration in the selection of color of ink and paper.^{3,9}

- Thousands of people are temporarily color deficient because of changing physiological condition.^{1,2}

- Many color deficient people are not detected when tests are given in incorrect environments.^{1,4}

Many people do not read very well. According to studies to determine their number and reading level:

- The average grade reading level of the 14,000,000 deaf and hard of hearing is very low.³⁵

- About 25,000,000 people are functionally illiterate (reading at the 5th grade level or less).³⁵

- Approximately 37 percent of the adult population, or 45,000,000 people, read below the eighth grade level.⁴⁸

- About 50 percent of high school teenagers in one study could not pass simple recognition tests of traffic signs, and reading of traffic tickets and simple instructions.³⁷

- Senior citizens applying for Social Security benefits have difficulty understanding the application forms.¹⁸

Although each statistical study is attacked on the basis of methodology, predictive value, or on possible applications of the conclusions, enough people appear to be visually handicapped by printers and publishers to justify the need for printing and publishing guidelines.

Guidelines for printing and publishing are needed to make the printed word more easily readable and understandable. If applied, they would make it easier for the general population to read, resulting in increased reading speed, reduction in "tired eyes," increased understanding, and sharpened memory of what is read, reduction of accidents, perpetuation of independence, facilitation of com-

munication, and benefiting mobility.^{41,44,45,47} There is no doubt that reading under bad conditions, such as not having enough light, poor contrast of printed letters against paper, the use of very small print, glare, etc., can lead to "tired eyes."^{11,12} Loss of reading for some or all persons is affected by:

Readability: Understanding due to the style of writing.

Visibility: Identification of a printed character or form.

Legibility: The ease with which reading matter can be understood under normal reading conditions.^{13,14}

Some of the words in this analysis are in printers' terms. It is hoped that the definitions and use of these terms will be understood.

1. Type Style Selection

"Type," in printing language, is a small block of metal or wood that has a raised letter or character on the upper edge that, when inked and pressed upon paper, is used to make a printed impression on the paper.

Type is generally classified into "serif" and "sans-serif." Times Roman is a serif type. A serif is a fine line finishing off the main stroke of the "T." Sans-serif is type without serifs. Helvetica is a sans-serif type. Although both serif and sans-serif are legible, a study showed that the serif was preferred by readers.^{13,34}

There are many designs in the appearance of type:

This line is printed in Times Roman Regular Type.

This line is printed in Times Roman Bold Type.

This line is printed in Times Roman Italic Type.

This line is printed in Helvetica Medium Type.

This line is printed in Helvetica Medium Bold Type.

This line is printed in Helvetica Medium Italic Type.

Bold print is a broad image of type, and "italic" is a slanted image of type. Bold and italic type are used when an author wants to show that a statement or idea is more important or more significant than the general text. In a study, it was found that italic print is read more closely than ordinary type, particularly when the material is read in low light or when printed in a small type size.¹³ The printing of large amounts of reading material in italics should be avoided. It was suggested, also, that bold face type, although extremely legible, should not be used for general purposes.¹⁴

With the increasing use of computers, many organizations are publishing computer printouts as reading material. Computers are equipped with a type with all capital letters. The use of all capitals reduces reading speed from 10 to 20 percent.¹⁴

THIS IS A SAMPLE OF MATERIAL PRINTED IN ALL CAPITALS IN HELVETICA LIGHT TYPE, SIMILAR TO THE APPEARANCE OF A COMPUTER GENERATED REPORT.

2. Type Size

The size of type affects visibility. The unit of type size is the "Point." The American point is about 1/72 inch in height. Thus a 12 point letter is about 1/6 inch high.

This line is set in 14 point type.

This line is set in 12 point type.

This line is set in 11 point type.

This line is set in 10 point type.

This line is set in 9 point type.

This line is set in 6 point type.

This line is set in 2 point type.

Eleven point type shows the best speed of reading, and it has been concluded that 11 point type is the best for general printing use.¹⁴ When vis- 5

ually limited people are considered, however, 12 point type should be used. The use of small print (6 to 8 points or smaller), which is commonly found in newspapers and in book footnotes, slows reading considerably and is not good for general reading.¹⁴

For those persons with seriously impaired vision, corrected to 20/200 to 5/200, the smallest type size recommended is 14 point.^{5,28,30,32,33} Many of these people can read 14 point without special magnifying apparatus. (Note: Problems occur in leading while using 14 point type unless precautions are used. See below.)

3. Line Leading (*pronounced "ledding"*)

One line of print is made from one row of type. Frequently, the next row is jammed directly below the first row. Material printed with no extra space between rows of type is said to be printed "solid." There appears to be a space between lines only because the image of the letter takes up a little less than the full height of type.

Sometimes, an extra space is put between the rows of type. The unit of points is used to measure the space. The space is called "leading" (pronounced "ledding"). The amount of space or leading used in printing is usually 0 to 2 points. The use of 11 point type with no leading is written 11/11. 11 point type with one point of leading is written 11/12, etc.

This line is Times Roman Type set 11/11 or solid and demonstrates no leading between lines.

This line is Times Roman Type set 11/12 and demonstrates one point of leading between lines.

This line is Times Roman Type set 11/13 and demonstrates two points of leading between lines.

This line is Times Roman Type set 11/14 and demonstrates three points of leading between lines.

6 Although leading is helpful for leg-

ibility, the benefit of leading for legibility is less important for reading the larger size type (11, 12 points).^{14,34} One point of leading is adequate for this larger size type. Two points seems to be the best for most line widths.¹⁴ On the other hand, too much leading can slow reading speed and understanding by showing too much "white space" between lines. Extra leading increases printing costs without any positive result. Type size/leading for the aging population should be 12/13 or 12/14.

In preparing copy for those people who need 14 point type, an editor will select a smaller type and enlarge it photographically to the 14 point size. Many typesetters charge less this way instead of setting the type in 14 point type. The risk in enlarging the type, however, is that the leading is also enlarged. Enlarging 8/9 becomes 14/18, giving four points of leading. Enlarging 9/10 becomes 14/16, resulting in only two points of leading.

The need for leading is affected by type style selected. As was described earlier, the character or letter sits on the edge of the type. The letter does not use the full space allowed, *e.g.* an eleven point type letter could use as little as 7 points of height. The balance of the type space which prints no letter image gives effectively becomes leading. Printing eleven point type on one point of leading, *i.e.* 11/12, but using a type face that uses only 7 of the eleven points for the letter, gives the visual appearance of being a seven point high letter on four points of unprinted type plus the one point of added leading. This results in an effective visual image of 7/12, seven points of letter on five points of leading.

Depending upon the type face selected, anywhere from 60 percent to 85 percent of the available space is used for the actual letter. When print-

ing for people with limited vision, it is best to consult the printer's type specification book to find the nicest type face with the largest percentage of letter for the type size you are buying. From a cost standpoint, if the type selected uses only 60 to 65 per cent of the type, consideration should be given to using less extra leading for line separation. Instead of printing 11/12 or 11/13, it may be possible to print a very readable image if printed 11/11.

4. Proportional Spacing, Hyphenation

A type style that slows reading speed is the "American Typewriter," the standard type face used on many typewriters. Many organizations use typewriters to make camera ready copy to give to the printer.

The most obvious source of reading problems with typewriter type is the uniform width for all letters. Letters in our language are not the same width. The letter "i," for example, is less wide than the "w." American typewriter type allows the same amount of width for the letter "i" as for the letter "w." The use of extra white space on each side of the letter "i" and other narrow letters, and the elimination of all white space on each side of the letter "w," retards reading speed.¹⁵

IBM modern type, however, is typed with so-called proportional spacing. Proportional spacing allows for adjustment between letters to eliminate white space when it is not needed, and to allow extra space for the wider letters. Speed of reading tests showed that reading speed increased with proportional spacing with no loss of understanding by the reader.¹⁶

If regular typesetting is not used for camera ready copy, every attempt should be made to use typewriters with proportional spacing.

A study has shown there is no loss of reading speed with the use of irregular line widths with no hyphenation,^{14,16} but there is no available study regarding the use of hyphens and their bad effect on reading speed.

Because hyphens break up words and require the reader to remember the last syllable on the previous line, a hyphenated syllable at the end of a long line can present the reader with the problem of testing his memory. People with limited vision and poor memory (a problem of aging) might have problems reading and understanding material in hyphenated lines.

5. Line Width (Length)

The width of a line, *i.e.*, length from left to right, is measured in picas. There are six picas to an inch. A five 5 inch line is 30 picas wide.

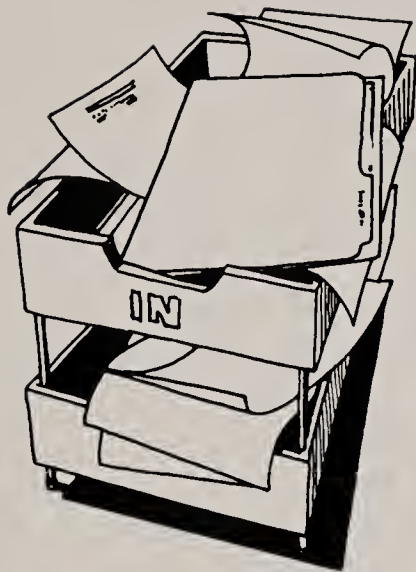
There is a loss of reading speed in the use of wider line widths, but the loss is not really important until the line width is more than 5-½ inches, 33 picas.¹⁴

In a study of line width, it appears that the very best line width for both 11 and 12 point type is just over 4 inches (25 picas) plus or minus 1-¼ inch (8 picas.)¹⁴

6. Columns

The use of more than one column on a page is one way of making full use of a piece of paper 8-½ inches wide. A study showed that on an 8-½ inch sheet of paper, 7-¼ inches could be filled with print without slowing reading speed by having two columns, each 3-⅞ inches wide, with ¼ inch margins on both sides and between the columns.¹⁴

Separations between columns can vary from ½ to 2 picas of white space. Sometimes a vertical line or "rule" with from ¼ to 2 picas of white space on each side is used. In a study, all arrangements were shown to be equally legible, but the readers preferred a vertical line with a ½ pica



space on each side of the line.¹⁴

7. Paragraphing

Leaving out indentation at the beginning of paragraphs may result in a pleasing "modern" look. A study has shown, however, that splitting reading matter into many short paragraphs of a sentence or two with the first line of each paragraph indented, improves speed of reading over using fewer and longer paragraphs.¹⁴

Instead of indenting the first line, skipping lines between paragraphs can be used. This provides at least as good a visual clue for paragraphs as indenting the first line.

8. Margins

The use of margins is expected by readers, and is often justified on the basis of esthetics, resting of the eyes before and after each line and page,¹⁷ focusing the reader's attention on the reading material by the "framing" effect, allowing more space for the writing of notes and comments, and allowing for wearing of the paper edges without ruining the reading area.

Speed of reading tests found that there was a reduction in reading speed for "curved pages" when smaller size margins were used in text

books.¹⁷ Inner margins should be made much wider than is usual in order to reduce the regular inner edge curve book pages and to improve legibility.

One margin that has not been studied much is the "wrap," "run around," or "floating margin." In some advertisements, and even in the layout of some magazine articles, a figure or photo is printed in the center of the page with reading material running along side, above, and below the figure. The typesetting of the reading material is to follow as closely the irregular edges of the figure, or photo, producing different line widths and irregular right and left margins. People with limited vision might give up reading any of the material because of "legibility" problems, difficulty in following the material to be read, possibly losing sight of some.

9. Paper and ink, contrast and reflectance

Seeing is a physical and mechanical operation. Light enters the eye and registers on the retina, similar to the operation of a camera. On its passage through the eye, light activates the rods and cones in the eyeball. The rods send light and dark impulses to the retina, and the cones send color impulses to the retina.

Color pigments around us absorb light. Theoretically, if there are no pigments or other light absorbing elements, light will be reflected 100 percent into the eye, and will register as white on the retina. When light is reflected off a piece of paper, a blade of grass, or off some clothing which contains a pigment of color, the pigment absorbs some of the light, reflects the balance of the light into the eye, and a color message of less than 100 percent reflectance is registered on the retina. Black pigment reflects from about zero to five percent light. Deep red reflects about 18 percent

light. Green reflects about 40 percent light, etc.

When someone is diagnosed as being "color blind" or "color deficient," it is because the cones in the eye are not activated by the lower intensities of light reflectance. The "red" and "green" color blind persons see those colors as gray because the color cones in their eyes need more light reflectance to be stimulated than the amount of light that the red or green pigment allows to be reflected into the eye.

As people get older, other physiological problems occur which reduce the sensitivity of the cones to the darker (less reflective) pigments. Clouding of the lens (cataracts) also interferes with the color impulses transmitted to the retina.

The use of color in ink and in the paper stock presents real legibility problems to color deficient people. They need a high degree of contrast in light reflectances between the ink and the paper. To see ink and paper as a color deficient person sees it, copy the material on a xerox or other copying machine. This will provide a copy with various shades of gray, and shows the effect of color as a contrasting medium. Darker colored paper (blue, green, pink) will come out almost black. (Some copying machines have adjustments to minimize this effect, however.) A test to see as a cataract impaired person sees is to put several sheets of amber colored cellophane or plastic (skiing goggles) over the material.

For better reading speed,¹⁹ and to increase the ability to read at a distance, black print on a white background is the best.²⁰ The only case for which white on black seems to be as visible as black on white is a sans-serif type in the larger sizes (10 to 14 points), preferably in medium or in

black on white is best. However, printing color photos in black and white does not provide enough contrast.

In using various colored inks on colored paper, it is found that the lightness contrast between the ink and the paper is most important.^{20,21,22,39} The light reflected into the eye is measured in Munsell value numbers³¹ and U.S. Government Printing Office (GPO) luminance (reflectance) percentages. The Munsell and GPO numbers are different but equivalent. In both cases, the higher the number, the more lightness is reflected into the eyes. The best contrast for reading is a high reflectance for the paper and a low reflectance for the ink.

Although 70 percent reflectance of the paper is recommended in the use of black ink on white paper,²³ 75 percent reflectance of the paper is necessary when *other than black ink* is used on white or tinted paper.^{23,24} All black ink should have a maximum of 2.18/ Munsell value equivalent to 3.6 percent on the GPO reflectance scale; colored ink must not exceed a Munsell value of 2.5/ equivalent to 4.61 percent on the GPO reflectance scale; paper should have a minimum Munsell value of 8.6/ equivalent to 70.37 percent on the GPO reflectance scale when used with black ink; and paper should have a minimum Munsell value of 8.9/ equivalent to 76.53 percent on the GPO reflectance scale when used with *colored ink*.²⁴

In an attempt to differentiate one publication from another, some editors and publishers use a different color paper for the covers. From an economy standpoint, it might work out just as well if the cover were white (for visibility and contrast of the black print), but a ½ inch dark ink colored border were used around the outer edges as a color-coded, identifying frame. This would enable stock

and shipping rooms and libraries to quickly identify issues, with no loss of title information.

10. Color Screens And Reversals

Photo images are broken up into hundreds of dots, a technique referred to as "screening." The photo is rephotographed through a screen of dots, the darker images of the photo activating more dots than the lighter. In printing, the areas with the most dots print darkest.

Screening is also used in color ink printing to provide different reflectances or brightness of color, giving the appearance of more than one "shade" of color. The sensation of seeing a different shade is the variation in the number of colored dots.

Sometimes graphic designers will specify a dark screened ink lettering on a lighter screened ink background to provide some color ink contrast. That is how dark green lettering on a light green screened background on a can of aerosol *seems* to have two colors. If there is enough contrast between the screened colors, it may be enough contrast for the visually limited to read. In the final analysis, however, it is the contrast between Munsell values or GPO reflectance of the two shades of ink that determines whether there is enough contrast to see the lettering against the background.

To provide the best contrast, only one dark shade of ink on a white background or on a light colored background should be used.

Problems in the use of screened inks occur in attempting to place reverse reading material (in white) against a lightly screened, colored background. There will probably not be enough contrast between the reversal (white) on the background of lightly screened, colored ink. If two shades of the same colored ink are to be used with a white reverse, it is bet-

ter to put the white reverse into the darker color background area for maximum contrast, and printing very dark letters on the lighter background.

Another problem in using reading material in reverse is the hazard of the background colored ink "bleeding" or running into white letters, producing color tinted letters instead of the needed white reverse, cancelling or diminishing the effective contrast. This can be caused by improper placement of a second color negative ("out of register").

Above all, reverse letter should not be smaller than 11 points, and should be in sans-serif, medium or bold face.

11. *Vocabulary Relating To Readability*

Long words and jargon can reduce legibility by obscuring meaning. The "unfamiliarity feature of material" suggests that the wrong choice of words can slow reading speed and reduce understanding.^{13,14,18}

Effort and money are spent translating written information for the 14 million deaf and hard of hearing into a limited and basic sign reading vocabulary which is limited in scope and meaning.^{8,35} The general public reads at a very low school grade level.^{18,35,36,37,48,49} Senior citizens have difficulty understanding written instructions and completing the application forms when they apply for Social Security benefits.¹⁸

As an incentive for writers and publishers to control their use of vocabulary, it is wise to consider that the use of smaller words with fewer syllables also reduces the amount of paper and ink needed to produce the product.

Examples Of A Need For Guidelines

1. The Washington Post Newspaper prints its news in a serif type in 8.5/9.5 points.²⁵ The leading of one

point is almost adequate but the 8.5 type size is less than our best size of 11 point for general reading use (12 point preferred). The Post also prints its classified advertisements, including the employment want ads, in a sans-serif type in 5.5/6 points.²⁵

Not only is the ½ point leading inadequate for use with a small type, but the size of type is illegible to all those with limited vision. If those people with limited vision and senior citizens wanted to find a job or buy a car through the want ads, they could not read the ads.

2. The manufacturer of individual packets of a sugar substitute containing a form of saccharine prints "warm red" ink on pink paper. This provides very little contrast for most people, and appears to red "color blind" people (protanopes) to be gray on gray. The warning about the dangerous effects of saccharine are printed in process blue which, to a color deficient person, provides very

little contrast on the pink paper. The warning and the contents of the packages are printed in 2 point sans-serif type, difficult for anyone to read, but it is legal under the federal regulations.²⁶

3. The telephone white page directory is printed in 6 or 6½ point sans-serif, well below the minimum range. Those people with limited vision are forced to call "information" for the desired numbers rather than strain their eyes to read the directory.

4. "No smoking" signs are printed with black ink on a dark red paper. The red color "blind" (protanope) sees the sign as black on grey. Fortunately, "Fire Exit" signs are usually printed with a good color contrast of red lettering on a white background.

5. TTY is telephone service for the deaf. Unfortunately, the simplest and less expensive TTY models display the message in red sans serif lettering on a dark background. This results in a gray on black image for the red 9

INFORMATION CENTER ON HANDICAP ISSUES

SERVING:

- Handicapped Adults
- Employers
- Educators
- Rehabilitation Professionals

FEATURING:

- *Telephone Information Service
- Brochures on Sections 503/402
- In The Mainstream: Newsletter on affirmative action for handicapped people
- Project HEALTH: Newsletter on Hospitals and 504

CALL OR WRITE:

MAINSTREAM INFORMATION CENTER

1200 15th Street, N.W.
Washington, D.C. 20005
(202) 833-1162* Voice/TTY

“color blind,” producing very little visual contrast.

Other more expensive models print out the message on paper similar to teletypewriter or by computer. A color deficient deaf person must either face difficulty with the red lettering model, purchase the more expensive printout model, or do without TTY.

Some federal forms are printed with type size that provides many people with reading problems:

- The Internal Revenue tax reporting form #1040 is printed 8/9. The instructions are printed 8/9 for the first 10 pages, then 9 point solid.

- There are many sizes used in the Census reporting form but most of the material is in 9/10.

- The report to the public of congressional discussions is set in 9/10 size but is further reduced for printing with a 97 percent reduction (8.73/9.7).

- A study of the Social Security Insurance benefit application form showed that the type size was too small and the vocabulary in the instructions was unintelligible to a large group of applicants.¹⁸

Suggested Guidelines

1. Serif face type is recommended for general text.

2. Sans-serif type is recommended for captions, headings, reversals and for limited use in small pamphlets.

3. Bold face and italic are to be used sparingly, never used in long passages of copy.

4. Avoid the use of all capitals for text.

5. Eleven point type is the best for general printing use.

6. Twelve point type is recommended for reading by those with marginal difficulty in reading (including aging).

7. Fourteen point (minimum) is 10 needed for those persons with seri-

ously impaired vision.

8. Proportional spacing is recommended.

9. Hyphenation at right margins is not encouraged.

10. One or two points of leading is recommended for 11 or 12 point or larger type.

11. Four points of leading should never be used.

12. No less than two points of leading should be used with smaller than 11 point type.

13. No more than two points of leading should be used with larger than 12 point type.

14. Line width (length) of 11 or 12 point type should not exceed 42 picas (7 inches) for single column text.

15. In the use of pages with multiple columns, columns should range between 18 to 28 picas wide (3 to 4½ inches).

16. Separations between columns are better with ½ pica on each side of a vertical rule (line).

17. Avoid “wrap” and “run around” irregular width lines as a margin.

18. Paragraphs should consist of a few short sentences with either an indent for the first line of the paragraph or a space between paragraphs if block style is used. Indenting is preferred.

19. Inner margins in a text book or in pamphlets of more than 20 pages should be larger than the outer side margins.

20. For general purposes publications, it is suggested that words with fewer syllables replace those words with many syllables. Words with restricted or limited use definition should be eliminated.

21. Black ink on white paper is preferred for type and for photos (reproduction of color photos in black and white is not satisfactory).

22. Black ink must not exceed a

Munsell value of 2.18/ equivalent to a GPO luminance of 3.6 percent.

23. Colored ink, must not exceed a Munsell value of 2.5/ equivalent a GPO luminance of 4.61 percent.

24. When used with black ink, the paper should have a minimum Munsell value of 8.6/ equivalent to a GPO luminance of 70.37 percent.

25. When used with colored ink, the paper should have a minimum Munsell value of 8.9/ equivalent to GPO luminance of 76.53 percent.

26. For economy and for color-coding, use a ½ inch colored ink framed border on the covers and spines instead of colored stock or full color covers.

27. In the use of screened color for background, with black or colored ink lettering the minimum Munsell value of the screened color background must be 8.9/ equivalent to a GPO luminance of 76.53 percent.

28. In the use of a screened color for background with white reverse lettering, the maximum Munsell value of the ink must be no more than 2.5/ equivalent to a GPO luminance of 4.61 percent.

29. In the use of reversals, the minimum size type in the reversal letters should be 11 point size on medium or bold sans-serif.

30. In the use of reversals against a screened background, the reversal lettering will have a minimum Munsell value of 8.9/ equivalent to a GPO luminance of 76.53 percent, and the background must have a value of no more than 2.5/ equivalent to a GPO luminance of 4.61 percent.

The Cost Factor

Cost per reader is the most important factor to consider in publishing. Low production costs that result in publications that are not visible, legible, or readable by a large percentage of the audience are a waste.

Mr. Ralph is a management analyst involved in developing technical assistance materials for recipients of federal assistance in the Office For Civil Rights, Department of Health and Human Services.

This article was written by Mr. Ralph in his private capacity. No official support or endorsement by the Department of Health and Human Services is intended or should be inferred.

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Correction

In the article, *National Council On The Handicapped*. . . , page 12-13 of the January-February edition of AR, the first five paragraphs were misplaced. The article reads correctly by moving these five paragraphs to page 13, just above the paragraph starting: "A summary of the forum's conclusions. . . ." Elizabeth DeFay, who assisted the Council with its agenda planning, should be credited as the author. The editor regrets this error.

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TELECOMMUNICATIONS AND DEVELOPMENTALLY DISABLED PEOPLE: EVALUATIONS OF AUDIO CONFERENCING, PERSONAL COMPUTERS, COMPUTER CONFERENCING, ELECTRONIC MAIL. Robert Johansen, Barbara McNeal, and Michael Nyhan. Institute for the Future, 2740 Sand Hill Road, Menlo Park, California 94025. (Report R-50). 235 pages. \$15.

RECRUITING QUALIFIED DISABLED WORKERS. An employer's directory to placement services in the Greater New York Areas. Lana Smart. Research and Utilization Institute, National Center on Employment of the Handicapped at Human Resources Center, Albertson, N.Y. 11507. 160 pages. \$5.95, plus .50 postage.

HANDICAPPED REQUIREMENTS HANDBOOK. Section 504 compliance in programs and institutions. The basic guide is \$80 which includes the handbook and monthly updates for a full year. Additional chapters that cover individually the government agencies are available for \$15 per chapter extra. Federal Programs Advisory Service, 2120 L Street N.W., Suite 210, Washington, D.C. 20037.

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EDUCATORS WITH DISABILITIES: A RESOURCE GUIDE. Produced by the American Association of Colleges for Teacher Education. Order from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Order stock number: 065-000-00104-7. \$5.50.

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PROGRAM EVALUATION IN VOCATIONAL REHABILITATION: OBSERVATIONS. James E. Taylor,

Ph.D., Rehabilitation Services Administration, Room 3529, MES, 330 C Street S.W., Washington, D. C. 20202.

INTRODUCTION TO INDEPENDENT LIVING REHABILITATION SERVICES. B. Douglas Rice and Richard T. Roessler. Publications Section, Arkansas Rehabilitation Research and Training Center, Hot Springs Rehabilitation Center, P. O. Box 1358, Hot Springs, Arkansas 71901. \$3.

CHANGING CONCEPTS IN ADJUSTMENT SERVICES. Arkansas Rehabilitation Research and Training Center, Hot Springs Rehabilitation Center, P. O. Box 1358, Hot Springs, Arkansas 71901. This is a report of a study group at the Sixth Institute on Rehabilitation Issues held in San Antonio, Texas, June 5-7, 1979.

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TAXES AND DISABILITY. The President's Committee on Employment of the Handicapped, Washington, D.C. 20210.

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AID BULLETIN. (Newsletter) Addiction Intervention With The Disabled, Care of Alexander Boros, Department of Sociology, Kent State University, Kent, Ohio 44242.

THE SIGNED ENGLISH SERIES. (Books, references, and posters available from The Gallaudet College Press) Gallaudet College, Washington, D.C. 20002.

Language Used or Used Language?

Obfuscation is a term that defines the art of utilization of many big words on the pretext that these words are

We overheard Irma Blunose observe: "About what is there to talk?" Ending prepositions, we remembered, were things up with which Sir Winston Churchill would put up with. Of such things, we are also capable of. It is an area that we are very involved in. We feel that, in relation to the rules of grammar, broadened criteria are called for. What are we bothering you for? Simply, to defend our point, we will use everything we can lay our hands on. Are you for or against? Think about it, then write us after

Superabundance. Sue these words for nonsupport.

The following bit of irony is quoted from Edwin Newman's book, *Strictly Speaking*:

"Moscow, Nov. 5—Marshal Boris P. Bugayev, the Soviet Minister of Civil Aviation, personally directed the successful foiling of an attempt to hijack a Soviet domestic airliner to Sweden last Friday, unofficial sources said today."

"The story went on from there, but it never did tell us how close Bugayev came to unsuccessfully failing the attempt to hijack the airliner.

"I do not recall seeing a report of a successful foiling before that one in the *Times* in 1973. The phrase had, however, a certain inevitability about it, the way having been paved by totally destroyed, completely destroyed, surrounded on three sides,

partially surrounded, completely surrounded, partially damaged, completely abandoned, completely eliminated, most unique, rather unique, very unique, and totally unique."

Careful Writing. Simple writing does not necessarily mean clear writing.

Bureaucratic Bias (*Good words that become vogue, and, consequently, vague.*) **Situation:** This is the situation: We no longer live, we are in a life situation; we no longer have emotions, we undergo emotional situations. But this word (to get in a truth situation) perhaps came first from a sports situation where football players often found themselves in a kicking situation and where baseball managers determine that their mound problems might be remedied through a replacement situation.

METHODOLOGY

The following is quoted from *The Washington Star*, but it originally appeared in *The American Legion* magazine. It might have been headlined: Bureaucracy Hath Its Monogram: "A government personnel clerk received a document, initialed it and passed it on. It promptly came back with this note attached: 'This document did not concern you. Please erase your initials and initial your erasure.'"

In the *We Don't Believe It* depart-

ment: The subheadline in a report reads: The Mailed Questionnaire. This is followed by this text: "By mailed questionnaire is meant a printed series of questions which are mailed to potential respondents who read and answer them themselves." (My! What will be thought of next?)

"Crass, boring, incomprehensible, inefficient and inhuman—all at the same time" is how the National Consumer Council describes Britain's 100,000 official forms. (The American bureaucracy can take some heart in the knowledge that it has 2,000 fewer forms.) The group is distributing labels that can be attached to the forms. The label says: "This is gobbledygook. Please use plain English."

The Promised Land. The difference between the right word and the almost right word is the difference between lightning and the lightning bug. *Mark Twain.*

"Scientific precedents have little weight with them (the Americans); They are never long detained by the subtlety of the schools nor ready to accept big words for sterling coin; they penetrate, as far as they can, into the principal parts of the subject that occupies them, and they like to expound them in the popular language." From "Why the Americans are more addicted to practical than to theoretical science," *Democracy In America* by Alexis De Tocqueville. Obviously, there were few social scientists writing in those days!

Well said; Worth Saying: A society obsessed by physical beauty should accept those who cannot conform to the norms of ideal beauty. If society is incapable, it is not the individual's fault. It's society's. A society that cannot accept the totality of its elements is itself fragmentary. Bette Stephenson, Ontario Canada's Minister of Labour.

Review: *A Rose For Tomorrow:*
**Biography of
Frederick C. Schreiber**

Edna Adler

At the time of this writing, over 2 years have passed since the death of Frederick C. Schreiber, nationally and internationally known for his leadership of the largest consumer group in the world. For 16 years, up to the time of his death, Fred Schreiber, a talented deaf man, was the extremely active and able head of the American National Association of the Deaf.

The story of his remarkable career, cut short by his early death, is told in the book, *A Rose For Tomorrow*. The author, Jerome D. Schein, a professional associate and long time friend of Fred, has put together a book that should have meaning for

those who may not have known him as well as for those who did. In essence, the story of Frederick C. Schreiber is the story of the struggles of the American deaf community to organize itself and to better itself. As the central figure in an action theatre having a great many parts and involving singularly and jointly such disparate groups as the grass roots deaf community, professionals, government officials, the Congress and the White House, Fred Schreiber evolves throughout the book as the exceptional individual he truly was.

Dr. Schein has incorporated in his biography a number of the papers and speeches he wrote in his role as chief spokesman for the deaf consumer. His writings, always refreshing, reveal an insight into the problems far ahead of their time. His handling of controversial issues, whether delicately or with bluntness, seriously or with humor, is engaging in its forthrightness and penetrating thought.

A Rose For Tomorrow concludes with testimonies from the social and professional communities in which Fred Schreiber constantly and tirelessly moved. They form a fitting ending for the biography of a person whose values were inextricably bound to the fate of his fellow deaf men.

The National Association of the Deaf, 814 Thayer Avenue, Silver Spring, Maryland 20910 is the distributor of *A Rose For Tomorrow*. The price is \$14.95 (hard cover). Royalties from the sale of the book have been donated by the author to the Frederick C. Schreiber Memorial Fund.

Notes on the margin...

NO WALLS

A Center for Independent Living opened in Bridgeport, Conn. It has no walls or meeting place such as the term "center" implies. It serves as a clearinghouse that taps the resources of five major sponsoring agencies: Goodwill (lead agency), Parents and Friends of Retarded Citizens, Easter Seal Rehabilitation Center of Eastern Fairfield County, Division of Vocational Rehabilitation, and the Bridgeport Office of Handicapped Services. A component of the center is a Community School for Living, which offers courses in such areas as cooking, physical fitness, nutrition, medical needs, and banking. Senator Lowell Weicker of Connecticut said that such successful results can be achieved when individual agencies pool their resources and provide cost effective, nonduplicative services.

--Disabled American News

JOBS FOR BLIND

In partnership with the U. S. Department of Labor, the Job Opportunities for the Blind program operates a nationwide, toll-free number. Services offered by the organization include a job bulletin, public service radio announcements, recorded materials, listings of positions that are open throughout the country, seminars on blind and deaf-blind applicants to help them learn about their rights, improved job search skills, and more. The number is 1-800-638-7518.

FINANCIAL AID

The U. S. Department of Education has produced a disc edition of its guide to financial assistance to handicapped high school graduates. It describes the aid programs and vocational rehabilitation funds which are available to eligible students to continue their education. Write to: U. S. Department of Education, Office of student Financial Assistance, 400 Maryland Avenue S.E., Washington, D. C. 20202.

SEX WORKSHOP

Health professionals are invited to attend a weekend workshop on the sexual needs of disabled people sponsored by Moss Rehabilitation Hospital in Philadelphia, April 16-18. The program, called the Sexual Attitude Reassessment Workshop, is designed to help professionals explore their own feelings about human sexuality so that they may better understand the sexual needs of handicapped people. It is directed by Dorothea D. Glass, M.D., Moss medical director and renowned expert in the field of sexuality and the disabled.

Registration is limited; the fee is \$125 per person. Applications and a brochure may be obtained from SAR Workshop Coordinator, Moss Rehabilitation Hospital, 12th Street and Tabor Road, Philadelphia, PA 19141, or by calling (215) 329-5715.

SCHOLARSHIPS FOR BLIND STUDENTS

The American Council of the Blind is pleased to announce the establishment of the Floyd Qualls Memorial Scholarship Program. Four scholarships of \$2,500 each will be awarded this year to legally blind applicants who have been admitted for vocational, technical, professional or academic studies at postsecondary levels. Scholarship applications, instructions, and criteria may be obtained from the ACB national office at 1-800-424-8666. Applications, with supporting documents, should be addressed to the Floyd Qualls Memorial Scholarship Committee, c/o American Council of the Blind, 1211 Connecticut Avenue N.W., Suite 506, Washington, D.C. 20036. Applications must be received by April 30, 1982.

SAFETY CONGRESS

The 52nd All-Ohio Safety Congress and Exhibit will be held at the Ohio Center, Columbus, from April 20 to 22. On-the-job safety is the theme, and the Congress is free and open to the public. For more information, contact Larry Whalen, Manager, at (614) 466-8633, or, toll-free, 1-800-282-3045.

NISH CONFERENCE

The National Industries For The Severely Handicapped will hold a National Conference in San Antonio, April 25-27. More information: NISH, 4350 East West Highway, Suite 1120, Bethesda, MD 20814.

New Concepts And Directions In Rehabilitation

George A. Conn

The role of government has been addressed by tribal leaders, clan chieftains, pharaohs, Athenian senators, Roman emperors, and feudal monarchs of both oriental and occidental persuasion; also, popes, dictators of infinite variety, prime ministers, and presidents. In this society, where leaders govern with the consent of the governed, I think Lincoln put it best when he said, "Government should do only that which people cannot do for themselves."

Certainly, in a country where the individual is invested with a maximum degree of freedom through a 200-year-old, written constitution, shored by 200 years of case law, the governed must accept an equal measure of responsibility to ensure the system's dynamic balance and perpetuation. Moreover, to be successful, the system must seek to achieve universality. We can be proud of being members of a society where the search continues, expanding its reach to the most vulnerable population subgroup in our midst . . . disabled people.

Though this country has not witnessed internal armed conflict for 115 years, it has had to deal with the human flotsam and jetsam of subsequent foreign wars. Coincidental with World War II and the return of more than 1 million G.I. casualties, came the development of mass-produced penicillin and advanced methods of dealing with emergency evacuation, acute and subacute medical interven-

tion, and comprehensive rehabilitation.

As a result, another factor has been added to the complex, pluralistic society we call America; that is, 31 million disabled individuals, and another 20-25 million super citizens who cope with infirmities related to advanced age.

For the past 20 years, disabled Americans, aided by colleagues, spouses, and friends, have petitioned government at all jurisdictional levels for improved services and a body of law respecting equity of opportunity in all phases of community life. The thrust of all these focal mechanisms has propelled disabled Americans into unprecedented participation in the everyday life across the breadth of the Nation, and set an example for the rest of the world. But then, being ourselves, and faced with a sputtering economy, we now find ourselves in the midst of a periodic assessment of our current status.

Within the world of disability, at the federal level, we are presented with an amazing panorama, for there is no single focal mechanism of compelling purpose. Rather, there is distributed throughout the federal fabric an incredible array of programs. At the Department of Health and Human Services, we find the Social Security Supplemental Security Income and Social Security Disability Insurance programs, the Developmental Disabilities Administration, the President's Committee on Mental Retarda-

tion, and the Title XIX Medicare program. Previously, HHS housed the Crippled Childrens' program under the aegis of the Maternal and Child Health agency . . . (This program is now "blocked" to the states under the Budget Reconciliation Act.)

The Department of Health and Human Services is merely a single example of the fragmentation, and duplication, of programs for disabled persons. Similar fragmentation and duplication occur in the Departments of Education, Labor, Housing and Urban Development, Interior, Justice, and Transportation, not to mention the Veterans Administration. This situation creates two problems. One exists in the Executive Branch of the Federal Government, and speaks to the great difficulty in developing agreements between existing departments and agencies for the purpose of developing a coherent, rational, positively directed, and substantive generic program for the provision of services to disabled individuals. The second problem persists within the Congress, with its confusing matrix of jurisdictional committees and subcommittees related to the budget, authorization, and appropriations processes.

This Administration seeks to reduce duplication and fragmentation of such programs. There is a growing perception throughout the country, among consumers and professionals in the field of rehabilitation, that we must look to new concepts to provide

improved management and direction to these programs.

Specifically, we must address ourselves to the problem of the proliferation of programs, which are, or tend to be, cosmetic. At a time when the infusion of public funds into programs designed to assist those in need are in fact creating economic hardship throughout the Nation, one must be persuaded to review existing programs with an eye to folding them into substantive programs, with resultant reduction in budgetary levels. Indeed, logic would argue that public funds would be best used to support the direct provision of necessary services to disabled persons who are in the greatest need, and that limitations be placed on ever expanding administrative overhead and salaries and expenses.

Medical intervention, habilitation, rehabilitation, education, placement, and long term care constitute phases in a disabled person's life. I would suggest that what is needed is a generic program that calls for the provision of a continuum of services to disabled persons from the onset of the disabling condition, and wherever and whenever appropriate, provide access to such services throughout that person's lifetime.

The Administration has outlined its priorities very clearly to the American people. These priorities include the development of job opportunities, the control of inflation through the reduction of the federal budget, a comparable reduction in federal regulatory requirements, and the stimulation of the economy through personal and corporate tax reductions.

The Administration has taken action on two of the four elements mentioned above. These include a tax cut and a substantial reduction in the federal budget. The drive to reduce regulatory budget is under way. It is

headed by Vice President Bush and is under review at the present time.

In the area of employment of disabled people, the White House and the Rehabilitation Services Administration have undertaken the following initiatives:

1. Project Partnership has been established by Mrs. Virginia Knauer, who has responsibility for programs affecting disabled persons in the United States. This is a pilot project to enlist the aid of chief executive officers of major corporations in employing disabled persons and making recommendations to the White House with regard to tax incentive programs in employment, housing, and transportation.

2. RSA has argued for increased funding for Projects With Industry for the fiscal year 1982. Projects with Industry has demonstrated its value over the years as a most successful interface between business, industry, and labor and rehabilitation for improving, and expanding, employment programs for disabled persons.

In addition, as Commissioner, I have asked that the targeted job tax credit provision be retained as a specific incentive to employment of disabled persons. Also, I have suggested that the rehabilitation community and the private sector begin to explore the potential benefits to be gained should corporations purchase "sheltered workshops" as wholly-owned divisions. Benefits accruing to the workshop would be capital and a steady source of cash-flow operations. The benefits to the corporation would be accelerated depreciation of existing facilities and equipment, and a well trained and reliable workforce. Other tax incentives under exploration include expansion of the present \$25,000, one-time tax credit and making a place of business accessible to a two-tiered system providing a

larger sum for a major cooperative facility and a reduced amount for multiple facilities used in franchised operations.

I must address the inherent cultural and economic limitations related to compliance and affirmative action. Unfortunately, such programs are subject to bureaucratic abuse. In the case of compliance, reasonable accommodation can be misconstrued to become unreasonable accommodation. This vexing problem must be reviewed from a statutory and regulatory standpoint. Certainly, there is great potential for resolving problems of access and accommodation through Executive Order and voluntary effort.

Throughout the years as an advocate for civil measures on behalf of my fellow disabled individuals, I have stressed equality of opportunity for qualified persons. Whereas the Declaration of Independence and the constitution confer certain rights to all individuals in a specific context, the great body of case law emphasizes equity of opportunity. It is this which is the foundation of our efforts on behalf of disabled Americans. Should any entity in our society wish to enlist the participation of disabled persons beyond their proportionate representation in our population, those entities should have an opportunity to do so.

Finally, it is important that we strengthen the traditional partnership of the State-Federal Rehabilitation Program. For 60 years this mutual effort has provided critical services to disabled Americans. During these 6 decades, there has evolved within this cooperative endeavor a core of leadership, experience, and knowledge of considerable proportion. The private sector has used this entity as a model in recent years. While there remains a need to modernize the process of rehabilitation, we must work to create a strong and active partnership with the



Photos on this page are representative of a meeting held at the White House to honor the 1000th placement through Projects With Industry. Top photo, left to right, Mr. Glen R. Solomon, Chief Consultant to the Electronics Industry Foundation; Mrs. Virginia Knauer, Special Assistant to the President; Mr. James T. Magee, President of EIF; and Mr. George A. Conn, Commissioner, RSA. Photo above shows honored employee, Mr. John Vargo (see box on page 23) and below are assembled guests.



private sector though an emphasis on postrehabilitation placements in remunerative occupations. Through this effort, disabled people will achieve the independence and dignity we all seek as citizens of this great land.

Mr. Conn is Commissioner, Rehabilitation Services Administration. This paper is based on a presentation that he made to the Menninger Foundation Projects With Industry Advisory Council in October 1981.

New Publications

Sexual Expression. Carl Hartman, MSW, Jane Quinn, MSW, and Brenda Young, MSW. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. 208 pages. \$14.95.

This practical, illustrated manual is specifically designed to promote sexual awareness in individuals, couples, and groups. The reader is offered a series of progressively ordered exercises that encourage comfort with one's sexuality. The manual also addresses such topics as treatment approaches, modules of practice, and current trends.

Family Therapy. Gerald H. Zuk. Revised Edition. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. \$13.95. 351 pages.

Reflecting advances in the author's thinking during the past decade, this revised edition analyzes the changing configuration of the American family and its direct effect upon social maladjustment and mental illness in children and adolescents. The author describes the most effective sources of leverage available to the therapist and explains their practical application in the clinical setting.

(Continued on page 24.)

The New Wave in Rehabilitation: Projects With Industry

James T. Magee, Thomas J. Fleming, and James R. Geletka

Dr. Karl Menninger, world renowned psychiatrist, believes that 87 percent of emotional problems in America are "job-related." Work occupies such prominence in our lives that many people will spend 20 to 30 years in study and training for special jobs. "What do you do?", is one of the questions we ask when we first meet someone. "What you need is a job where you can meet some interesting people" is the usual advice we give to a friend who wants for new social contacts.

We have created major societal institutions—the public school system, public and private colleges and universities—whose primary purpose is preparing people to go to work, often for very specific jobs. The military services recruit by promising a skill that can be used to get a job later. We tend to plan our lives around our jobs—where we will live, when we go on vacation, how we dress, the image we convey to others.

Working and the job is not only the primary means of economic self-sufficiency, it is also the central element of social cohesion.

Yet, there are millions of U.S. citizens who exist within the milieu of the work world but are insulated from full participation.

These people are the unemployed disabled. The barriers that keep them

from entering into such a fundamental life activity are complex. Some are physical—buildings, factories, schools, that are architecturally inaccessible. Others, however, are more insidious. They are the obstructions of prejudice and misconception that are based on fear and ignorance.

For nearly 60 years the state-federal vocational rehabilitation program has effectively labored to achieve progress in the employment of disabled people. Now a new effort, "Projects With Industry," is extending this support system and building on it to develop a new partnership with business and industry. This program is contributing dramatically to the number of disabled people entering into jobs in the private competitive marketplace. This alliance between business leaders and rehabilitation practitioners not only brings heightened economic status to disabled people, it also has broad and significant social and political implications for society at large. Because of the magnitude of the problem, billions of dollars are at stake in the delicate balance between success and failure.

Several recent U.S. Department of Labor studies set the number of unemployed, disabled people able to work at between 3.5 and 7.1 million. The U.S. Department of Education's

Rehabilitation Services Administration estimates this total at 5 million and reports that, were support for increased rehabilitation services available, the majority could successfully engage in competitive employment.

A consideration of the impact that the employment of so many people would have on the U.S. economy, by itself, demands that priority be given in government planning, legislative action, and future funding. Estimates purport that an unemployed disabled person, even to live marginally, requires a minimum of \$5,000 in the form of payments from such sources as welfare or social security. With an estimated 5 million unemployed, disabled people, the annual cost to American taxpayers is computed at about \$25 billion, approximately 3 percent of the total federal budget.

If employed, even at the current minimum wage, these people would generate more than \$35 billion in wages. When combined with the tax savings, it means a \$60 billion advantage to the economy. This is in itself not an insignificant sum; however, if the number of disabled persons is closer to the White House Conference on Handicapped Individuals figure of 10 million, the benefit to the economy would be \$120 billion.

There is little doubt that disabled people with training geared to the 21

manpower needs of industry and business could be readily absorbed into the private sector. The resulting integration of millions of disabled workers could effect the conversion of an existing, significant negative inflationary factor into positive component for application in the production of essential goods and services. Such production, exchanged in the marketplace, would significantly enhance the Nation's gross national product—an important consideration, since a 1 percent unemployment rate results in \$26 billion loss in goods and services produced, not to mention an equal amount in tax revenues.

The emergence of Projects With Industry as a successful approach to employment problems of disabled people is highly encouraging. Under the partnership arrangement between the business community and rehabilitation, the management and leadership responsibility for vocational rehabilitation is shifting to the private sector, away from the traditional social service arena. Rehabilitation principles and practices are still involved in this relationship but in the context of providing services to enhance the nature and quality of the collective effort. The PWI program represents the logical evolution of national vocational rehabilitation efforts into a placement system for disabled workers in competitive employment. In this way, the same free enterprise approach of competition in the production of goods and services which has raised the standard of living and the quality of life for the able-bodied offers the same rewards for the disabled.

The thrust of the PWI program is on results: quality control, highly sophisticated business and industry training standards, competitiveness, marketing techniques, and reward for high performance. In this environ-

ment, disabled people vie for jobs using specialized and often superior training, related directly to the manpower needs of business and industry. Often the training is in highly technical, or "targeted scarce occupations," arming disabled people with an extra edge in competing for jobs. They are sought after by employers who recognize their potential as skilled, dedicated, productive workers, who will contribute to cutting employment costs and increasing profits.

For disabled people, it is an opportunity to share in the social and economic rewards of a democratic society as well as attain full citizenship rights.

However, our society has for too long sheltered and isolated hundreds of thousands of disabled people in institutions and sheltered workshops. Millions more have been confined to their homes or to marginal employment. Misconceptions about disability have resulted in prejudices and barriers that continue to exclude this large population from the workplace.

In *The Unexpected Minority: Handicapped Children in America*, authors John Gliedman and Willan Roth claim that a major obstacle to the integration of disabled people in the mainstream is the mistaken notion that they are "sick" and need to "get well." Disabled people are looked upon as "perpetual patients," by a society which then proceeds, according to Gliedman and Roth, to ignore their needs in such areas as employment, housing, transportation, and recreation.

Projects With Industry is correcting such misconceptions through the direct involvement, commitment, and leadership provided by private businessmen. They contribute management skills and high-level technical and commercial competencies to

make the system work for disabled people. Disabled workers put the myth to bed forever by their successful endeavors.

More than 5,000 corporations and businesses are now affiliated with about 100 PWI projects (including 56 satellite extensions) sponsored by the U.S. Department of Education's Rehabilitation Services Administration. These projects vary in the specific services provided, but they have common threads, including the goal of competitive employment for all disabled participants, strong ties to the local labor market, and the involvement of industry and business in a senior management and leadership role.

More importantly, PWI offers disabled people a real opportunity to be self-sufficient and contributing members of society through responsibilities and paying taxes, as well as by producing goods and services needed by the Nation.

In a declining economy precipitated by recession or inflation, the PWI concept becomes even more significant, particularly with such expanding industries as electronics and other high-technology fields.

Bruce Carswell, Senior Vice President of General Telephone and Electronics Service Corporation (GTE) and Chairman of the Electronic Industries Foundation PWI National Advisory Council, has said that, in a recession, the need for skilled workers is even more critical. With increased unemployment comes competition for jobs and the need for greater production from fewer workers. "The ability to market the productivity and skills of disabled workers," says Carswell "will be essential."

PWI offers a functional approach to the problem by tailoring services to the specific needs of business and industry. As the primary policymaker in the partnership, business and in-

1000th Placement Honored At White House

The Electronic Industries Foundation's (EIF) Project With Industry (PWI) was honored in October 1981 at a ceremony held at the White House's Executive Office Building. Mrs. Virginia Knauer, Special Assistant to the President, and Mr. George Conn, Commissioner, Rehabilitation Services Administration, hosted the reception which recognized the achievement of the project's 1000th job placement of a disabled person.

Present at the ceremony were representatives of companies which chair the project's national and local advisory councils, including Control Data Corporation, GTE, Honeywell, IBM, ITT, Motorola, and TRW. Also attending were key executives from EIF and the Electronic Industries Association.

Attending as a representative of those disabled people who have been assisted by the program was John Vargo of Matteson, Illinois. His wife, Jonelle, accompanied him.

Mr. Vargo, who is deaf, was employed as an electrician in January 1981 by the Motorola Corporation in Schaumburg, Illinois. He received placement assistance from EIF's Chicago Area PWI project which is operated in partnership with the Rehabilitation Institute of Chicago (RIC).

For 6 years, Mr. Vargo, who has a B.S. degree, taught social studies to deaf students at a private school. When supporting his growing family became difficult on his \$5,050 salary, he contacted the Illinois Department

of Rehabilitation (DORS) for job training.

In August 1979, the 30-year-old Vargo enrolled in a vocational training program at Coyne American Institute in Chicago to become a certified electrician. He finished his course the following August and was named to the honor roll. After a few jobless months, he was referred to the EIF/RIC Project With Industry by his DORS casework supervisor. A PWI employment specialist, who works with dozens of electronic and other companies in the Chicago area, arranged an interview at Motorola in December 1980. A few weeks later, he was hired at a salary that more than tripled his previous earnings.

Along with helping Vargo, PWI staff assisted Motorola by providing information to tailor the electrician's job to Vargo's hearing disability and by aiding in communication between Vargo and his employer in the first days of his job.

According to John Kuzma, Manager of Employment and Professional Recruitment at Motorola's Communication Sector, Vargo is an excellent employee who performs his job well. "We provided him with a vibrating pager so he can be contracted when he is working out in the plant," Kuzma explained, "and his supervisor and coworkers communicate with him through hand signals and written notes. There are only a very few areas where John's disability limits him."

For his part, Vargo says he could be satisfied staying at his job until he retires; he likes it so well.

Industry designs the training, sets the qualification standard for workers, and manages or modifies the environment of the work area. These requirements and using the knowledge to effectively place disabled workers is at the heart of the PWI program.

Acceptance of this role by industry effectively bridges the gap between the social humanism of the traditional rehabilitation system, and private enterprise.

The great promise for the state-federal program of vocational rehabilitation and disabled people will be through the energy generated by the addition of business and industry to the system.

Mr. Magee is President, Electronic Industries Foundation while Mr. Geletka is a project manager in the Foundation. Mr. Fleming is Director, Projects With Industry Program, RSA.

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Waking Dream Therapy. Gerald Epstein, M.D. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. 222 pages. \$19.95.

Maintaining that the imagination is a vital psychological process for enriching our physical and emotional life, this book provides a guide to the clinical use of dreams, daydreams and fantasies. In essence, waking dream therapy consists of re-living a dream in the therapeutic setting while exploring the significant elements that constitute the dream setting or action. Therapeutic possibilities suggested by the dream are then carried out in the patient's waking life with the help of exercises explained by the author.

Directory of Mental Health Programs and Resources for Hearing Impaired Persons. Raymond J. Trybus and Terry A. Edelstein. Gallaudet

Street and Florida Ave. N.E., Washington, D.C. 20002. \$3.50.

Entries in this publication are listed by state. It presents both programs (service units designed to provide clinical mental health services to hearing impaired people) and resources (agencies or private practitioners who routinely deliver clinical services to hearing impaired people).

Each program and resource description includes the name of the director, program address and phone number, services offered, program capacity, professional staff, and date of establishment. Since it is a directory, it does not evaluate the programs or services, nor do listings in it constitute endorsement by the Gallaudet Research Institute.

Drug-Free Therapeutic Community. Robert C. Brook and Paul C. Whitehead. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. \$14.95.

This book explores the philosophy and use of the therapeutic community in the treatment of drug-dependent people. In addition to evaluating significant research, it provides a broad variety of historical and contemporary studies to assess critically the effectiveness of therapeutic communities. A major section is devoted to the systematic observation of a treatment program for amphetamine abusers.

Living Environments For Developmentally Retarded Persons. H. Carl Haywood and J.R. Newbrough, editors. University Park Press, 300 Charles St., Baltimore, Md. 21201. 335 pages. \$29.95.

Thirty authors contribute papers to this book in a variety of areas, such as social-ecological concepts, community orientation, issues in residential placement, and problems in evaluation and implementation.



Photo by JO2 Dallas Bellamy

It was hard-hitting, high-scoring beep ball (baseball for the blind) action at Point Mugu (California) as the Naval Air Station sponsored Mission Missiles downed the Simi Valley Burners, 21-9. It was also the Mugu team's first home game and first win.

RADM Fred H. Baughman, Commander of the Pacific Missile Test Center, was in the stands as the Missiles

worked their way toward victory.

KEYT-TV3 of Santa Barbara covered the game and highlights of the play were aired that evening.

The Mission chapter of the Telephone Pioneers, (a public service organization made up of 20-plus-year employees of Bell) also sponsors the Missiles, supplying uniforms, equipment, and personnel support.

Blind Beep Ballers Belt "Burners"

Dallas Bellamy, JO2

Beep ball is played with a softball-sized beeping ball, three different sounding beeping bases, seven numbered lanes (one for each fielder), a bat and a batting tee. The batter is lined up with the ball and allowed five strikes to get a hit. When the ball goes into play the number of the lane it lands in is called out as one of the three bases starts to sound.

The object is for the runner to get to the base before the fielder finds and holds up the ball. Action is fast paced as team members test their skills of hearing and coordination.

Larry Woods, (Oxnard), the Missiles' team manager, said it was good team effort and competitive spirit that helped the Missiles win. Sandy Remson, (Oxnard), and Mike Finn, (Camarillo), were the team's high scorers each belting four homers. Woods said Rick Harris, (Oxnard), made an inning-saving field play to stop a rally by the Burners.

"Beep ball gives blind and sight impaired individuals another dimension in their quest for independence," said Ed Sanders, (Oxnard), Handicapped Program Manager and founder of Point Mugu's Beep ball team.

Mr. Bellamy is a Journalist 2nd Class stationed at the Naval Air Station, Point Mugu, California. The photos accompanying this article are by him also.

NEWS, NOTES, ANNOUNCEMENTS

A Tale Of "O" Is No Tic Tac Toe

Affirmative action is no joke. But a group of corporate consultants thinks that their humor-filled cartoon production can ease tensions around it.

A Tale of "O" is a slide-tape for internal use by corporations to aid in exploring and solving the problems encountered by women and minorities entering management today. It was conceived by Dr. Rosabeth Moss Kanter, and produced by Dr. Barry Stein and the staff of Goodmeasure, Inc., a Cambridge, Massachusetts management consulting firm.

The graphics and text of the slide-tape are also the basis for a book to be published this spring by Harper and Row.

A Tale Of "O" developed from research by Dr. Kanter, who is Professor of Sociology and Professor of Organization and Management at Yale. After years of work with major corporations, she found the problems of women and minorities in management to be similar to those faced by anyone alone in a group composed largely of another kind of people. After publishing her award-winning book, *Men and Women of the Corporation*, Dr. Kanter joined with Dr. Stein to experiment with ways to present her findings to corporate clients in a simple, yet forceful manner.

In talking to managers, they illustrated the findings with simple line drawings showing one "O" in a group of many "X's". The use of O's and X's to represent people, instead of emotion-laden terms such as "black," "white," "men" or "women," allowed audiences to dis-

cuss the problems of tokenism with a new openness, an awareness that led to solutions. And the use of humor and drawings made a difficult subject easy to swallow.

Kanter and Stein saw the potential for many corporations to benefit from serious research findings communicated in a colorful way. *A Tale Of "O"* is the result. The first simple X and O line drawings were transformed into a set of full color cartoon slides by a skilled graphic design team. The narrative became a multi-voice soundtrack, with music, special effects, and a pun-filled drama.

The aim of *A Tale Of "O"* is to help both X's and O's understand what happens to the "few" in work groups composed of "the many." Its goal is to encourage managers, employees, men, women, whites, blacks and other minorities to see the common human dilemmas of people who are "different"—and then to cope more productively.

The audio-visual presentation lasts 27 minutes. It is accompanied by an instructor's manual with bibliography. Synchronized slide-tape is \$490, plus shipping; ¾ inch videotape is \$560, plus shipping; and rental is \$150 (3 days). Order from Goodmeasure, Inc., 330 Broadway, Cambridge, Mass. 02139.

Two NYC Laws Signed

New York City Mayor Edward Koch has signed two bills of importance to the disabled community of New York City.

The first allows the City Commission on Human Rights to investigate—and settle—complaints of dis-

crimination filed by people with physical or mental disabilities. The law gives the city's commission powers similar to those of human rights agencies at state and federal levels.

The law enlarges the meaning of "physically handicapped" to include people with disabilities that may not require them to use a crutch, brace, or other device. Also under the protection of this law are people with a mental handicap who cite discrimination.

The second law allows wheelchair accessible vans, while picking up or discharging handicapped passengers, to be parked in any restricted area where vehicles with a special vehicle identification permit can park. This legislation codifies an informal practice which has been followed by most parking enforcement officers.

Visions, United Cerebral Palsy of New York City, Inc.

Language Aid Used With Deaf Students

Teachers who want to show students how to choose correct verb endings—or even whole words—may want to try a technique developed by English teachers at the National Technical Institute for the Deaf (NTID) at Rochester Institute of Technology (RIT).

In a controlled experiment with 34 students who were born deaf (and thus who don't usually master the language system used by hearing students), teachers flashed target words, or sections of words they wanted the students to understand and master, in capital letters, so they'd stand out from the lower-case letters.

For example, when students needed to understand the verb ending -ed instead of -es, the experimental group saw the word flashed in front of them three times this way: "Newton stud-

ied the motion of bodies". The instructor used a technique which presents both print and sound to students at the same time with the help of an inclass computer. According to NTID English specialist Andrew Malcolm, any teacher can use the system. "The flashing word technique we developed is a sophisticated update to the proven teaching method of using repetition and focused emphasis to drive home a point."

The flashing word technique works, and student errors were only *one-fourth* what they were when the instructor used a more traditional system. Students averaged 83 percent correct answers when the instructor used only the lower-case letters. But, when flashed capitals were used, students average 96 percent correct answers.

Playground For Kids Built By Disabled

An Ottawa Canada school for disabled children has had a playground built, geared to the special needs of these children.

The playground was built by mentally and physically disabled adults for the John Butler School, which teaches communications and self-sufficiency to 32 severely mentally and handicapped children. It is the brainchild of Joe Silverman of the Young Adult Training Centre in Ottawa and Larry Arpaia, supervisor of the school.

The playground has gentle slopes for scooters, hills for rolling—a skill which develops flexibility—steps at different heights so children can practice coordination and swinging hammocks.

There is also a wide slide that allows space for a teacher to accompa-

ny a child, sandboxes high enough for children who are in wheelchairs or who are propped up against standing boards, a mixture of sand, grass, wood, and asphalt textures for children who are blind or deaf. The playground is also open to any child in the neighborhood.

The 1,000 pieces of the playground were each measured, cut, sanded, and varnished by about ten adults indoors during the winter. "I had to teach them how to work together: how to read the diagrams and models, how to measure, how to use the power tools, how to sand and file, and how to assemble the pieces," said Mr. Silverman.

"The structure is proof that handicapped people can build playgrounds. If given the opportunity, they can build additions to homes, cottages, whole houses and then, perhaps, even cities," said Mr. Arpaia.

Device To Help Disabled Person Produce TV Film

Television and other audio-visual endeavors will now be simpler to produce by mobility inhibited people with a system called ATCam, designed by Gene Linder of the American Television and Communications Corporation (ATC). The system incorporates a portable hookup to the disabled person's wheelchair that will allow him to film and record in any area accessible to his wheelchair.

The Sony 1800 camera and mike are mounted on a stand and are controlled by the operator at seat level with a lever that allows tilting and panning the camera; two other attachments allow zoom and focus operations. A monitor and viewfinder are located at operator eye level. The ensemble is completed with lights and a tape deck.

ATC, located in Englewood, Colorado, is making these units available free to disabled people within its franchise areas. Further information may be obtained from Gene Linder, ATC, 160 Inverness Drive West, Englewood, CO. 80112. Telephone: (303) 773-3411.

Military Scientists Find Hormone Useful In Spinal Cord Cases

Three military scientists have discovered the actions of a hormone produced in the hypothalamus (a gland near the base of the brain) that may be of significant value in preventing paralysis from spinal cord damage. The hormone is called TRH (thyrotrophin-releasing hormone).

The scientists induced spinal cord injuries in cats, waited an hour (to approximate the travel time to a hospital), and injected the subject group with THR, while giving a placebo to a control group, and a standard injection to a second control group. Several cats in each control group died; none in the treatment group.

After 6 weeks, the level of paralysis in the surviving cats in the control groups was severe, while that of the treatment group appeared entirely cured.

According to the scientists, who reported their study in the *New England Journal of Medicine*, TRH prevents paralysis by inducing the brain to raise the spinal cord area blood pressure. This, in turn, increases the flow of oxygen to the damaged nerve cells, a factor that was previously inhibited by other physiologic reactions to the injury. In addition, TRH does not interfere with the body's natural action to fight the pain due to the injury.

Handicapped Work Program Pays Dividends in Military

Marge Sanders

When the Naval Air Rework Facility (NARF), Pensacola began a pilot special emphasis work program for severely handicapped personnel two years ago, officials could hardly anticipate its overwhelming success. These handicapped people, who under normal circumstances would not be afforded job opportunities, were brought aboard, trained, and gainfully employed.

The idea for inaugurating this program occurred to Captain Joseph Walter, Commanding Officer, after he had met several mentally handicapped citizens during the annual Combined Federal Campaign. The possibility of such a program was discussed with Frank Cherry, an aircraft electrician and the father of a mentally retarded daughter, who was later selected to spearhead the effort.

As a first step, the local rehabilitation center was contacted and presented with a plan that proposed no charity, but rather, useful jobs which would benefit the NARF, the individuals, and the community.

It was relatively easy to place the physically handicapped in various trades throughout the NARF. The mentally retarded posed different problems. They were initially trained as sweepers and file clerks, but the real dividends paid off when a reclamation shop was established.

In an activity like the NARF, it takes the combined efforts of over

sion of providing repair and maintenance services to the Navy, Marine Corps, and other services. Divided into over 70 trades, encompassing both management and manual skills, the employees represent the real capability of the facility. Some of the skills necessary to operate the facility are in the hands and minds of handicapped persons. It takes a lot of things—concerned people, in-place community services, and industry ready for the benefits and challenges of providing opportunities to those with the skill and courage to grasp it and succeed. For the program to succeed, many things had to be done.

A two-fold search effort was conducted; first, to identify short-falls of skills that could be filled by handicapped people and second, to identify within the NARF structure other needs that could be filled to the mutual benefit of both the NARF and the handicapped people. With potential employment areas and necessary skills identified, an attempt was made to match the skills of handicapped people to these real needs.

Prodigious numbers of small parts, nuts, and bolts accumulate on the hangar floors during the many stages of aircraft disassembly. Collecting and sorting these items is a time-consuming process, and using highly paid artisans for this task was simply not cost effective. Consequently, this material was frequently discarded or stored but not reclaimed. In April of 1980, handicapped employees began sorting and returning for use these "scrap" items that ranged in price anywhere from a few cents to \$65. Special equipment was devised for the reclamation shop to



accommodate its workers, and a training program was established at the community rehabilitation center. Thus, workers reported to the job already trained, and an efficient operation was quickly turning out impressive results. During the first three months of reclamation effort, a net savings of \$50,000 was realized, after the workers' salaries were paid. Savings continue to run between \$10,000 to \$15,000 each month.

NARF Pensacola's program started with four handicapped employees and has grown to over 40. Besides sorting nuts and bolts and desoldering electrical connectors for reuse, handicapped individuals are effectively employed in a variety of other areas, including such diversified applications as filing IBM cards alpha-numerically, sewing, and labeling containers.

They also do such tasks as cleaning plastic file protectors (they used to go in the trash); putting new labels on manila file folders; and cleaning and emptying microfilm cartridges. All of these items are returned to offices/shops and reused. Some 1,000 potting tubes, which are filled with a sealant used on aircraft, are cleaned by a mentally handicapped woman each week and returned to shops. Before the reclamation shop was formed, new tubes were purchased at 50¢ each. They are cleaned for about 5¢. Savings continue to run in the thousands of dollars monthly.

The program is doubly beneficial in that it not only relieves the state of supporting these individuals, but it also provides the NARF with a source of highly motivated workers.

There's no doubt NARF officials involved in the Special Emphasis Program are very much encouraged by all the praise and the success of the program which lends credence to the motto, "It pays to hire the handicapped."



Photo, page 28, Frank Cherry instructs handicapped employees in sorting and reclaiming aircraft hardware, a savings of between \$10 and \$15 thousand per month. Above, Audrey Phillips cleans sealant potting tubes at a cost of 5 cents per tube. Tube costs 50 cents new. Below, Captain Walter watches employee Judy Kersey file parts.



Self-Actualization of Rehab Counseling Students: Pre And Post Comparisons

Bobbie J. Atkins, Ph.D., Ann B. Meyer, Ph. D.
and Christopher I. Stone, Ph.D.

The need for master's level education for rehabilitation counselors is well documented in the literature.^{1,2} Graduates of master's degree programs in rehabilitation are more perceptive and alert to methods for enhancing the service delivery system and more inclined to work with the more difficult to rehabilitate people.³ Other supporters of graduate education in rehabilitation counselor education (RCE) suggest that master's level counselors are better prepared to deal with the complexities required to understand the impact of disability. In addition, they are equipped to coordinate services that ensure a viable rehabilitation program. Funding from the federal rehabilitation agency (Rehabilitation Services Administration—RSA) to RCE programs is an additional example of value placed on the master's degree for them.

The graduate curriculum focuses on personal and professional growth and development so that they can better assist disabled people in self-exploration and goal attainment. Maslow defined a self-actualized person in terms of a number of clinically observable characteristics such as "increased acceptance of self, of others, and of nature . . . increase in problem centering . . . greatly increased character structure. . . , and

certain changes in the value system."⁴ Clearly, these characteristics are desirable for rehabilitation counselors and RCE program faculty are concerned with their graduates' possession of sufficient levels of self-actualization to become effective practitioners. Additionally, the American Rehabilitation Counseling Association standards for preparing rehabilitation counselors recognize assisting students in developing self-awareness and understanding.

An unfortunate limitation of research has been a lack of clear, empirical evidence relating counselor roles, functions, and characteristics to client outcome.⁵ Similarly, Wright and Trotter stated that "there is a lack of empirically-based information concerning the personality characteristics and interests of successful counselors."⁶ As the rehabilitation counselor is increasingly required to assist disabled people in all areas (e.g., independent living skills), information which helps identify desirable counselor characteristics is crucial. In addition, knowledge of these characteristics are invaluable employment evaluation tools as well as student selection criteria.

An example of research-based information concerning counselor qualities was directed by Patterson. He re-

ported that certain general qualities are desirable, for example, "an absence of guilt or inadequacy feelings, allowing others to make their own decisions,"⁷ which are consistent with rehabilitation philosophy and goals. Therefore, a problem area warranting additional exploration by RCE programs would be the development of empirical methods of systematic measurements of student intrapersonal functioning.

The Personal Orientation Inventory (POI), developed by Shostrom,^{8,9} is an instrument which assesses a person's level of self-actualization. Previous research suggests that the POI assists in assessing the level of student and graduate self-actualization.¹⁰ "Tentative results suggest that scores on the POI are highly stable and sufficiently valid measures of health-growth dimensions of personal functioning."¹¹

Since the authors contend that educators should foster increased student self-actualization, they hypothesized that master's level RCE program graduates would possess higher levels of self-actualization than when they entered the program. Students accepted for such a program, it was assumed, would possess the potential for enhancing their intrapersonal skills. Thus, the study's purpose was

to determine the difference in self-actualization existing between and graduation from the REC program, as measured by the POI.

Method

Subjects. They included 23 graduates of the RCE program at the University of Wisconsin—Milwaukee. Twelve were female and 11 male, with ages at the time of posttesting ranging from 23 to 44 years (with a mean age of 28). At graduation, 19 were employed in rehabilitation and related areas; the status of the remaining 4 was unknown. There were 4 blacks and 19 whites.

Instrument. The POI was used as a measure of self-actualization attainment. The POI is a 150-item, self-administered, personality inventory. It measures both behavioral judgments and certain values considered useful in determining self-actualization. According to Shostrom, a self-actualized person is one "who is more fully functioning and lives a more enriched life than does the average person."¹² It is a paper-pencil inventory composed of paired-opposite statements, comprised of 14 subscales. A number of studies support its value as a measure of self-actualization.^{13 14 15}

Procedure. The POI initially was administered (pretest) during their first semester in the RCE program at the University of Wisconsin—Milwaukee in the *Introduction to Rehabilitation Counseling* class. They were informed in general terms that the POI was a measure of personal orientation and in specific terms that their responses in no way would affect their course grade. They were encouraged to provide honest responses and told that they would be asked to complete the inventory again during their last semester.

These same subjects were asked to complete the POI (posttest) during the

Table 1
Means and Standard Deviations of POI Scales

POI Subscale	Pre-test		Post-test		Difference Post-Pre	Dependent
	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	t(22) ^a
Time						
Incompetent (TI)	4.65	2.52	3.87	2.80	-.78	-1.62
Time Competent (TC)	18.44	2.45	19.13	2.80	0.70	1.56
Other Directed (O)	34.70	11.00	30.00	10.60	-4.70	-2.35 *
Inner Directed (I)	92.13	8.48	97.00	10.40	4.87	2.89 **
Self-Actualizing						
Values (SAV)	20.70	1.99	21.44	2.09	0.74	1.36
Existentiality (EX)	23.30	3.59	24.39	4.82	1.09	1.66
Feeling						
Reactivity (FR)	17.17	2.39	18.13	2.67	0.96	1.62
Spontaneity (S)	13.30	2.12	14.09	1.95	0.78	1.64
Self Regard (SR)	13.00	1.54	13.13	1.82	0.13	0.32
Self Acceptance (SA)	16.61	2.98	18.52	3.40	1.91	3.81 ***
Nature of Man (NC)	13.09	1.76	13.44	1.70	0.35	1.28
Synergy (SY)	7.70	0.77	7.65	0.94	-.04	-.18
Acceptance of						
Aggression (A)	17.39	2.23	17.61	3.34	0.22	0.35
Capacity for						
Intimate Contact (C)	20.65	3.04	21.70	3.47	1.04	1.55

^aTest for \bar{X} (Difference) = 0 *p<.03 **p<.01 ***p<.001

last 2 weeks of their internship in rehabilitation counseling which is taken in the students' last semester in the RCE program. The posttest instructions were identical to its previous administration.

Results

For each of the 14 POI subscales, the subjects' pre and post means and standard deviations were calculated, which are presented in Table 1. A two-tailed dependent *t*-test was then used to analyze the mean difference between posttest and pretest data.

Of the 14 subscale pre-to-post differences, 3 were statistically significant: Other Directed [$t(22)=2.886$, $p .009$]; and Self-Acceptance [$t(22)=3.806$, $p .001$].

Discussion

On the three subscale changes (Other Directed [O/], Inner Directed [I/], and Self-Acceptance [SA]) that were found to be statistically significant, the mean scores were very similar to those of Shostrom's self-actualizing subjects. An interesting difference between the subjects' pre (34.70) and post (30.00) mean scores on the O subscale was noted. The subjects' mean score was less at the time of posttesting, indicating that these students became less Other Directed as they approached graduation. Based on Shostrom's definition of Other Directed as "dependent, seeks support of others' views,"¹⁶ this finding is supportive of other descriptions of the effective counselor as one who is more independent and/or self-reliant.

The decrease in the mean on the O subscale was in contrast to the Inner Directed mean which increased at the time of posttesting (see Table 1). This statistically significant finding was consistent with the results obtained by Trotter, Uhlig, and Fargo using the

considered to be a measure of non-self actualization and has a negative relationship to the Inner Directed subscale.

Although only 3 of the 14 subscale differences between post and pretest means were statistically significant, the results suggested that the experiences of students involved in a graduate education program for rehabilitation counselors lead to progress toward self-actualization. Specifically, it was suggested by Shostrom that the I subscale is a major assessment of self-actualization and Knapp¹⁷ attested to the importance of this subscale when he pointed out that "one hundred and twenty-three of the 150 items are scored for the inner direction scale making it the most representative overall measure of the self-actualization concept as measured by the POI." Similarly, Foulds¹⁸ found that the POI was a useful instrument in differentiating effective and ineffective counselors. The two subscales which were found by Foulds to be the most potent discriminators of counselor trainees who possessed high rather than low genuineness were Inner Directed and Capacity for Intimate Contact.

Because the I subscale has been found to be such a powerful measure of self-actualization, this study's findings suggest adopting student selection procedures that bring more fully functioning people into master's degree programs. Should additional research find a meaningful relationship between Inner Directed and Self-Acceptance to successful client outcome, RCE program staff could institute personal growth training courses to facilitate student change consistent with constructive psychosocial changes in disabled clients.

The finding that growth on the Self-Acceptance (SA) subscale was highly significant ($p .001$) was not inconsis-

ent with other research results involving rehabilitationists and the use of the POI. In their study on self-actualization and rehabilitation counselor success,¹⁹ Trotter, Uhlig, and Fargo found that Self-Acceptance was one of three subscales which was predictive of rehabilitation counselor success. Self-acceptance, as measured by the POI, is the person's self approval in spite of known weaknesses. For the counselor working with the disabled, this characteristic is desirable since many people who become disabled will need assistance in accepting their altered status. Therefore, counselors who accept themselves regardless of their own limitations can serve as potential role models and as positive influences for disabled people.

As stated previously, one of the goals of master's level education in rehabilitation is directed toward increasing the student's growth, development, and understanding of positive mental health. The significant changes over time on the O, I, and SA subscales indicated that some positive growth and development had occurred. One might ask, of course, whether the gains experienced were the result of an actual increase in self-actualization or simply an enhanced awareness of the appropriate and expected responses to items on the POI. Moreover, since no meaningful control group could be established, the observed outcome could be credited to maturation. Nevertheless, these findings regarding O, I, and SA suggested that enhanced self-actualization had taken place.

Clearly, additional research is required. Further investigation could focus on determining the value of the POI as a screening tool for use by faculty in RCE programs during the student selection process. Accordingly, future research employing the POI

could have valuable implications for predicting student success in training programs for counselors.²⁰ Additional inquiry is needed to determine if the findings in this study hold for other students in other RCE programs at the master's level. The relationship of counselor self-actualization on client outcome similarly deserves further study.

Dr. Atkins is Assistant Professor and Assistant Coordinator, Dr. Meyer is Professor and Coordinator, and Dr. Stone is Assistant Professor and Assistant Coordinator, Rehabilitation Counselor Education Program, Department of Educational Psychology, University of Wisconsin-Milwaukee.

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TOPIC OF STATE

Star Studded Slide Show Debuts In Cal.

Only a few production details need to be worked out before the audio-visual version of California's *Client Information Booklet* will be available in field offices. The audio portions of the slide and sound presentation will be narrated by two well known Hollywood stars: Tom Bosley has recorded the English version while Ricardo Montalban will do the Spanish narration.

Bakersfield District Program Supervisor Steve Rockett did a great job of coordinating development of the slide presentation, getting volunteer and expert assistance from a number of sources. He contacted Bob Cole of P.A.T.H. (Performing Arts Theater of the Handicapped) to arrange for Bosley's participation in the project and secured Montalban's services through William Schallert, well-known actor and president of the Screen Actor's Guild. Previously, Rockett had arranged for staff at Disney Studios to volunteer to do drawings for the slides (*What's Happening*, May 1981). Columbia Studios donated the facilities and crew for tapings of Montalban's voice, while technical crews and recording for the sign language version were donated by the Cal State Northridge Center on Deafness.

When the project is completed, audio-visual versions of the *Client Information Booklet* will be available in English, Spanish, low verbal, and signed versions to provide counselors with an easy method of presenting the booklet to new clients.

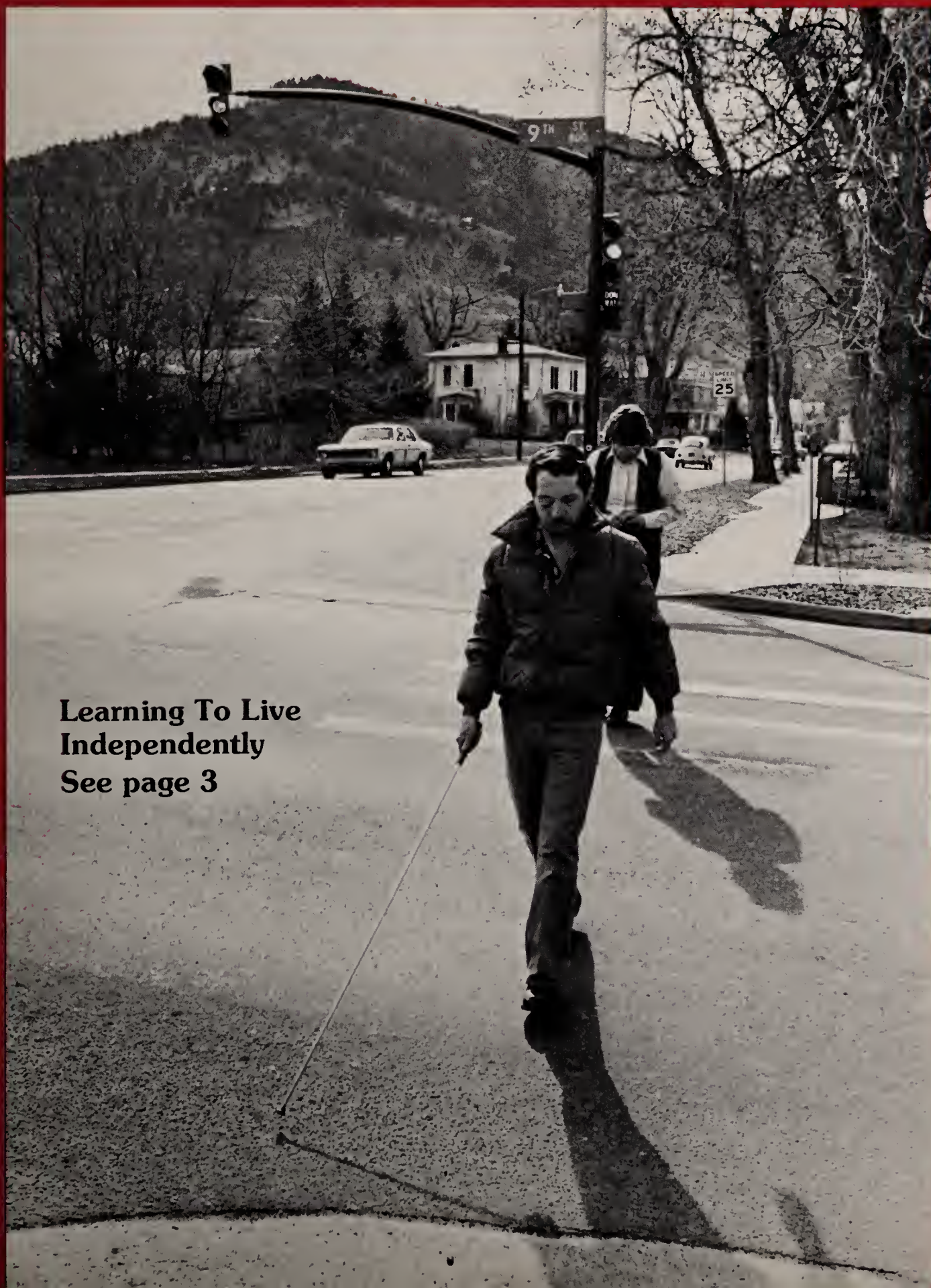
Rehab. Review, California Department of Rehabilitation.

Refund



MAY/JUNE 1982

AMERICAN REHABILITATION



**Learning To Live
Independently
See page 3**

COMMENTARY

. . . On Tone Of Article

I am writing concerning the article entitled, "Deaf Employee Hears With Hands" on page 32 of the January-February 1982 edition of *American Rehabilitation* magazine.

While I applaud the recognition of unusual skill and ability in the work of a deaf man, there is a tone running through the article which does the subject a severe disservice. At no point in the article is Danny Harris himself spoken with; all the information about him comes from his supervisor. Throughout the article, Danny Harris is talked about but never talked with, and the unavoidable implication is that he has nothing to say, while his hearing supervisor has lots to say. It may give the writer a feeling of warmth to describe a deaf person as "tall, ever smiling, a real person," and "a sharp individual," but both reader and subject would benefit much more from the publication of Danny Harris' own views and thoughts. To describe a deaf man through the words of others, without presenting anything of the person himself, heads us back in the direction of the "deaf and dumb" sensibility. If this person can hear with his hands, chances are that he can also speak with his hands. **Geoffrey S. Poor**, Counselor for the Deaf, Maine Bureau of Rehabilitation.

Ed's Note: I can't fight with that or add to it.

AMERICAN REHABILITATION

Volume 7, Number 5

The weakest ink is better than the strongest memory.

May—June 1982

3	Learning To Live Independently	Homer Page, Ph.D., Judy Mares-Dixon, and Judy Powell
10	Know Your Rights	Stephen Lichter and David Moore
11	Interagency Committee	Marcus J. Fuhrer, Ph.D.
18	Deafness Awareness	
21	Registration And Voting	Kathaleen C. Arneson
26	Review: Women And Disability	Kathleen Lloyd, M.D.
30	Mumps And Hearing Loss	McCay Vernon, Ph.D., and Carol Hyatt

DEPARTMENTS

Cov. II	Commentary	24	New Publications
2	Topic of State	28	News, Notes, Announcements
16	Notes On The Margin	32	Report Resources
20	Language Used		

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TOPIC OF STATE

Mini Seminars Explain Disabilities To New Employers

The Pennsylvania Office of Vocational Rehabilitation's traveling seminar for private and public employers of the handicapped—"Understanding the Handicapped Job Applicant"—has been funded for fiscal year 1982 through a \$43,600 grant from the Governor's Special Grants Program (CETA).

Originally a federally-funded three-day affair held monthly at the Hiram G. Andrews Center in Johnstown, the program format was changed last year to half or full-day "mini-seminars" held on the employers' premises.

Broader Audience

This broadened the potential base of participants to include second-level personnel staff and supervisors in addition to employers and personnel managers that had attended the three-day version. (The three-day version, which offers the additional advantages of interaction with handicapped people training at the HGA Center, is still available to employers preferring it.)

For its faculty the mini-seminar draws on locally available experts in physical, mental and emotional disabilities, often themselves handicapped. Program content centers on the employability of qualified handicapped job applicants.

Attitude Change

As participants become aware of the abilities of the handicapped and of their own unfounded negative attitudes about them—as information dis-

2 places preconceptions—they develop

a capacity for rapport and communication with the handicapped.

The employer may specify the particular disability areas that present a problem in his organization. Among the topics most frequently requested are musculoskeletal disabilities, hearing and speech disorders, blindness, mental retardation, mental illness and alcoholism. There is no cost to the employer.

For further information write to Dick Potts, 13th Floor, Labor and Industry Building, Harrisburg, Pa. 17120, or phone (717) 787-5098.

—*Success*, Pennsylvania Office of Vocational Rehabilitation.

Devices On Horizon

The Veterans Administration's rehabilitative engineering program at the Georgia Institute of Technology has developed two new devices that are expected to be available for general use within 2 years.

One is a small device about the size of a calculator to aid people whose speech is impaired. It can be programmed with 112 different messages, allowing the user to display an entire phrase by tapping out a cipher in Morse code. This device will be particularly useful to persons whose motor reflexes, as well as their speech, are affected by their disability.

Another device is designed to help people with impaired vision locate important places (such as building entrances, rest rooms, water fountains, etc.). It consists of a buzzer mechanism which is attached to the place to be located which can be activated by a hand-held transmitter. When the user punches out a code on the keyboard, the doorway or whatever will give out a buzz to allow the person to locate it by following the sound.

Rehab Review California Department of Rehabilitation.

Windmills A Winner

A new awareness training program called "Windmills" is receiving widespread international attention as a very effective weapon against attitudinal barriers. Developed by the California Governor's Committee for Employment of the Handicapped as an IYDP project, "Windmills" is aimed at the myths, fears, and stereotypes that stand between people with disabilities and jobs. The entire program consists of 12 one hour training modules which can be used separately or together. Exercises in the modules deal with every day work experiences, which make it easy for participants to relate to what they're learning and apply it to their own situations.

Training kits for "Windmills" include slides, program aids, and cassettes and can be purchased for \$205 including tax and shipping charges. They can be ordered from ADEPT, 14547 Titus Street, Suite 110, Panorama City, California 91402.

Color Me Aware

The Los Angeles Fire Department has produced an excellent coloring book with a dual purpose. First, it gives children important tips on fire safety and prevention with short, easily understood statements illustrated by drawings to color. Next, it serves as a tool for disability awareness by depicting some of the characters in the drawings as having visible disabilities. The fire safety messages are also drawn in simple sign language.

Called the *Special Junior Firefighters Coloring Book*, this unique book is being distributed by the Governor's Committee for Employment of the Handicapped and can be obtained from them or the Los Angeles Fire Department at no charge.

Learning To Live Independently

Homer Page, Ph.D., Judy Mares-Dixon, and Judy Powell

Transition living programs have become controversial in the independent living movement. This has resulted from the tendency in some programs to keep a person in the program beyond what would be a fair length of time for a transitional experience. In this paper, we wish to assert the importance of a transition living program in a comprehensive independent living center. We also want to make a case for a specific approach in operating such a program.

The Center for People with Disabilities (CPWD), located in Boulder, Colorado, is a comprehensive independent living center that has existed since October 1, 1977.

On May 1, 1979, CPWD opened a transitional living program which operates in six apartments leased from the Boulder Public Housing Authority. The units are fully equipped, one bedroom apartments, located in a small apartment complex near Boulder Creek at the foot of the Rocky Mountains. A common meeting room, kitchen, and administrative offices are located in the same complex.

At this writing, the project has existed for 2 years and 4 months. During that time, 27 students have entered the program. The average time of participation is 6.2 months. One student stayed for 13 months and 2 others have stayed for less than a month. In the first instance, the severity of the student's disability (she was deaf and blind with cerebral palsy) made finding housing difficult. She consequently

stayed in the program a few months longer than would otherwise have been the case. In the cases of the students who left within a month, the program simply was not right for them.

The Process

The process in which a student develops a growth plan, takes part in the curriculum, prepares to leave, and actually exits is one of continual evolution. It is structured, and it is followed.

Transition living programs should provide a wholistic developmental experience. Skills should be taught, but attitudes should be a crucial focus for the program. Social, recreational, and vocational concerns are equally as important as skills of daily living, attendant care management, and knowledge of community resources. The process's end should result in independence and self-support for the student. Skill, self confidence, and self-regard are all to be sought.

The process begins with the intake procedure. Referrals are made by family members, hospitals, and community agencies. It is important, however, that the person be ready and interested to set out on a rather structured course, which thrusts him into a wholly new lifestyle. Risk is involved. The student needs both to understand and to be willing to accept this. Upon acceptance, a tour of the facilities is arranged. Where appropriate, family participates in the intake; they, too, tour the facilities. Family is also advised of the student's risk in pursuing a

course of independent living. Medical records are sought and reviewed with the potential student; broad goals are established; and objectives are set.

One of the most important phrases used during the intake procedure is, "When you leave, the expectation is clearly communicated from the beginning that this is a transition experience and that the student will be leaving the program within a few months."

If needed, personal care assistance is set up. Other special needs are addressed before the student moves in.

During the first week, emphasis is placed on basic maintenance. Staff and volunteers make sure that the student eats properly and that other basic needs are met. An individualized growth plan is developed with the student, based on the assessment of the student's needs during this first week. The plan focuses on skills of daily living such as food preparation, apartment management, and personal care. (In some instances, this means instructions on how to boil water safely!) Special techniques for preparing food and cooking are found if needed. Other helpful adaptations are found or designed. The basic maintenance phase is completed during the first month.

At first month's end and monthly thereafter, a progress evaluation is conducted in which the student participates. Progress toward the accomplishment of goals and objectives is assessed, areas needing further work are identified, and objectives for new areas are developed.

The second phase begins about the beginning of the second month in which social skills development are central. The student develops a plan for getting into the community. Volunteers go out to eat in restaurants with the student and he becomes involved in organized recreation, ranging from horseback riding to camping, swimming, or crafts. Students attend a local church of their choice. All students attend meetings of the Boulder Committee on the Handicapped. At this time, they are expected to find transportation to get to doctor's appointments and other engagements independently. Specialized therapies are initiated during this phase, which include physical and speech therapy, or personal counseling.

During phase one, the student remained largely in the sheltered atmosphere of the transition living program, but in phase two, he moves out into the community and deals with the public's attitudes toward disability and with his own attitudes, as well. Latent feelings surface; turmoil ensues. CPWD staff is supportive but also must be firm about the requirement that the student work at his plan for moving out into the larger world. This is a time when the family must be supportive yet must encourage the student to pursue his objectives. Peer interaction is especially helpful. Students are encouraged in formal and informal ways to discuss their feelings with one another. Since students enter the program at different times, there is likely to be one who has gone through this phase and has progressed beyond it.

Phase three concentrates on developing the student's desired future lifestyle in which vocational training, education, or employment are key aspects. Housing is another important part, while relationships with others round out the formal dimension of this

Each student is required to volunteer or work. Career information seminars are conducted; students tour local employers, newspaper want ads are examined; and past employment, where relevant, is explored. The student assisted in developing a resume; techniques of interviewing are discussed; other job-search skills are taught. The program's goal is for each student to matriculate into a job or a placement in vocational training or school.

Students plan for their specific needs, related to accessibility, location near school or employment, and transportation. Housing affordability is also a major consideration, and both the public and private housing market are explored. The advisability of finding a roommate is thoroughly discussed.

Students are expected to participate in a weekly relations groups which explores the wide range of relationships that they are exposed to. Past, present, and future relationships are explored. Students share problems and assist themselves toward developing more effective relationships. Relationships with family members, dating partners, friends, staff, and often the general public provide the materials for this group. The group represents a milieu for reflection on some of the most intense feelings that a student may have. It also provides support and insight from other people who have had similar experiences. The peer involvement has made this group one of the program's most influential experiences.

We find that the majority of students are ready to leave the program in 5 to 8 months; but leaving, also, has its problems. A job or a school must be found, housing must be located, and the tasks of daily living must be confronted in new ways since program support ceases. Transportation must be arranged, and students must con-

front a certain amount of loneliness.

Again, at this stage, the staff must be supportive but firm. The student may find innumerable barriers to moving out. These barriers must be dealt with for what they are. Practical solutions can be found to those that are real, but those that are not must be honestly identified as excuses.

Once the student leaves, staff continues a casual relationship. Emotional support is provided, and, in some instances, assistance, but this is rapidly reduced since the student is encouraged to develop a new support system. Some students may be invited to return to act as peer counselors.

Those who are not successful return to their family or may move into a group home or other facility providing continuous care. An analysis of this group will be presented later.

The Curriculum

An important teaching resource is the continuous log, kept on each student and in which staff records student progress. The log's daily summary permits a close monitoring of student development. It also forces the staff to articulate both areas of growth and remaining problem areas. The log provides an objective basis from which staff, parents, other agencies, and the student can determine what activities the student may be doing and what progress is being made.

An intense curriculum moves students through the program's various phases. Although there are many, space allows for but three examples: food preparation, community and recreational involvement, and career information and development.

One of the most important, basis skills needed to live independently is that of food preparation; but there is more to feeding one's self than just preparing food. Upon entry, students receive instruction in cooking safety.



All photos on cover, page 5 and 9 by Brian Payne of Black Star. Cover photo shows Jay Davis on a "mobility run" with group coordinator Judy Powell monitoring the exercise. At left, Jay does a solo run. Above, two of the clients search want ads and followup with telephone call to prospective employers. At right, Bob Jackson has progressed beyond "boiling water" as he prepares a delectable stew. On page 9, at left, coordinator Powell gives Dave Lorschbough some book-keeping pointers. At right, Ms. Powell gives Princy Jensen instructions on using power lift to exit from van.



Table 1
Student Successes And Failures By Type Of Disability

SUCCESSFUL DISABILITY		LENGTH OF TIME IN PROGRAM (Months)	HOUSING ARRANGEMENTS	TYPE OF EMPLOYMENT OR EDUCATION
RB	Epilepsy LD	4	Renting Apartment	Food Service
RC	Stroke Blind	6	Renting Apartment	Assembly
KR	Deaf, Blind CP	13	Renting Apartment	Receptionist
FL	PKU	7	Renting Apartment	Assembly
RA	MR	3	Renting Apartment	Maintenance
RB	Brain Injury	5	Renting Apartment	College Student
TW	MR	4	Renting Apartment	Sales
CC	CP	2	University of Colorado-Dorm	Clerical, Student
GL	Frederick's Ataxia	9	Renting Apartment	Bookkeeper
CZ	Brain Damage	6	Renting Apartment	Clerical
CA	Blind Epilepsy	11	Renting Apartment	Assembly
RL	Spinal Cord Injury	7	Renting Apartment	College Student
PARTIALLY SUCCESSFUL				
KM	CP Emotional	4	Supervised Facility	Receptionist
CL	Brain Injury Blind	11	Renting Apartment	Food Service
SP	MS	4	Own Home	Clerical
JB	Blind	5	Renting Apartment	Searching for Employment
TY	Blind	8	Renting Apartment	Searching for Employment
JC	Spinal Cord Injury	3	Hospital	N/A
RL	Brain Stem Damage	2	Renting Apartment	N/A

Table 1
(Continued)

FAILURES				
JG	Severe Epilepsy	9	Residential Facility	N/A
MJ	Brain Damage Toxic Plasmosis	3	Institution	N/A
JG	Severe Brain Stem Damage	3	Group Home	N/A
CURRENT STUDENTS				
RJ	Spinal Cord Injury	9	ILP	Clerk
EH	Brain Injury	6	ILP	Volunteer Work
CW	CP	4	ILP	N/A
RB	DD	4	ILP	WAT-Shop
DL	Brain Injury	3	ILP	WAT-Shop

This, of course, includes the use of a stove, cutting equipment, and other kitchen appliances. No student is allowed to work alone in the kitchen until the staff feels that the student can safely operate there.

Information regarding basic nutrition is given. The student then begins to construct a menu. A method for collecting and saving recipes is established. A shopping list is then constructed. The staff and student work out a transportation schedule for shopping, and, at first, the student is accompanied by staff or volunteer.

A deaf, blind woman (who also has cerebral palsy) uses a cab to go shopping. A friend calls the cab; she gives

the driver written instructions on where to go and when she is to be picked up. Once at the store, she delivers a pre-prepared list of her items to an employee who has been designated to work with her. Thus, even extremely severely disabled people can work out arrangements to function with a high degree of independence.

Upon return, the student learns what items need refrigeration; those that need no special treatment. An important part of food storage is the arrangement of the kitchen that allows access to items.

Food preparation is next. Early in the first week, the student's food preparation skills are assessed. Such things

as cutting, peeling, chopping, folding, and stirring are evaluated. Any special equipment which is needed is acquired. Cutting boards with special prongs or cut-outs may be needed. A microwave oven or a crock pot may be desirable. The student is then instructed with regard to actual cooking, such as baking, boiling, or broiling.

Within the first month, each student is expected to prepare a meal for other students. This meal is a type of certification point in the student's ability to handle this most fundamental daily living task. Once a student reaches the point that he needs to move into the larger community, discussions of personal interest are begun, often in the

peer group. The student is asked to make a list of desired activities. The staff then teaches the student how to locate the community resources which would potentially sponsor these activities. The yellow pages, the newspaper, radio stations that broadcast community calendars, and information and referral programs are used to discover if such activities are available.

After locating an activity of interest, the student is encouraged to enroll, or, if it is a community type, to attend the appropriate meetings. The student must work out transportation, must get any required equipment, and must do any necessary preparation. Again staff works with the student, but final responsibility remains with the student.

The staff works with students to develop specific goals and objectives for activities. The reactions of able-bodied people who will participate in the selected activities are anticipated and discussed. Throughout the experience, staff and students provide feedback to individuals as they reflect on the activity.

Career information and planning is the final example. A staff member and the student explore interest areas. The interests of the student are what are most important in determining the direction of the career information program. In some instances, assessment of interests through a formal testing procedure is useful to help the student focus on potential vocational areas. An evaluation of aptitudes may also assist the student to focus.

The person participates in weekly career information classes in which a variety of occupational areas are explored. They also assist the student to develop specific objectives for learning. The student may choose to tour an employment site, and, if so, is asked to set that up. The student may want to

sets a goal to set up a volunteer job in the relevant area. The staff works with the student to accomplish this objective.

Eventually obtaining career information leads to seeking employment. A job development workshop is conducted monthly where job search skills are taught. Entrants are asked to do a self-evaluation of job skills which are then discussed in the light of available jobs. A resume is developed, application forms are studied, and the student is asked to fill out some practice forms. The prospective worker practices discussing his disability, needed accommodations, and abilities to perform the job. The student then develops a game plan for locating a job and, during the following days, implements it. The staff and other students provide continuing feedback to the student during this tense and difficult time.

Each morning, staff and students meet to plan the schedule for each student during the day. During this time, other matters besides the schedule are discussed. If a student seems poorly motivated, or late to meetings, or especially difficult for others to talk with, he is likely to be challenged. Solutions are sought to these problems. The staff may use these times to deal with genuine problems but the morning sessions are also used to discuss daily news from newspapers. It is, after all, quite important that severely disabled people live in the larger world.

As the student becomes more and more involved in the community, volunteer work, job seeking, and other activities, he may be excused from the morning meetings. The curriculum is very structured early in the student's program, but, as the student advances, the schedule is less and less determined by the transition living program and more and more influenced by outside interests and activities. The curricu-

lum is designed to thrust the student into the community and free him from the transition living program.

Results

No matter how good a case is made for the programing of a transition living center, its ultimate effectiveness is determined by what happens to its students. During the past 2 years and 4 months, 27 students have participated. Of those, 12 are currently living independently, 7 are partially independent, 5 are still in the program, and 3, for a variety of reasons, cannot be considered to be living independently. (See Table 1.)

A person is considered to be living fully independently when he is both living in an apartment alone or genuinely in control and employed or attending an educational or vocational training program. People who are partially independent are only successful in one of the independent living measures. People who are not living independently have not been successful with either of the criterion. These criteria are simple. No attempt has been made to refine them because what really counts is whether a person is living independently. All of the technical advances that a student may make with regard to cooking, cleaning, etc. only count if the student can put them all together to create an independent living lifestyle.

Of the students who have left the program or are still in it, 12 are multiply handicapped, having one or another developmental disability, along with a physical disability; 5 are spinal cord injured; 4 have cerebral palsy; 1 has a form of muscular dystrophy; 2 are blind; and 6 are brain damaged. Summed up, the numbers yield more than 27, but the spinal cord injured also received brain damage in the accidents in which they were involved.



None of the people who entered the program were believed to be able to establish an independent living lifestyle without a sustained intervention. Fifty-five percent of the students who have left the program are fully independent. There are people who have been working now for 2 years; their job performance is more than adequate. They have proven to be successful employees. Of the 19 people who are fully or partially independent, only 4 are not currently employed. One of those is a young woman with a small child, under 2 years old. It is perhaps inappropriate for her to be employed, but she is caring for her apartment and her child.

Three persons have left the program and returned to a dependent lifestyle. One is severely epileptic. The high lev-

els of medication required to control his seizures have side effects that, for now, make independent living impossible. A second student, who has brain-stem damage, has demonstrated episodes of violent behavior. He currently is living under supervision. A third student left at the point of demonstrating psychiatric episodes.

The students who failed were no more severely disabled than those who succeeded. The students who have been unsuccessful have all experienced emotional or behavioral problems, excepting the one with side effects to heavy medication.

The students who have participated in the Center for People with Disabilities Transition Living Program prove that, if given a chance, they can succeed. We do not believe that we can

be successful with everyone who comes into the program. Not every severely disabled person succeeds; we believe that the strategy which we have developed and is outlined in this paper, holds out a significant promise to very many people who in the past have been considered only capable of a life in a custodial setting. This is a waste. We now know that most of them can work and be self-supporting, and that they can live lives of dignity and self-worth.

Dr. Page is Director, Office of Services To Disabled Students, University of Colorado, Boulder, and Chairman, Board of Director, Center for People with Disabilities. Ms. Mares-Dixon is Director and Ms. Powell is Coordinator, Transitional Living Program, Center for People with Disabilities.

Know Your Rights

Stephen Lichter and
David Moore

The Rehabilitation Act of 1973 establishes conditions under which you, as the consumer of services, can become a full partner in your own rehabilitation.

To insure this participation, very specific rights were identified by law. Legislation alone, however, does not insure consumer involvement or agency participation. An awareness of your rights is, essential to the fulfillment of your rehabilitation needs and goals.

The objective of this checklist is to present your rights to services and the ways in which you can expect these services to be provided. The checklist is designed to give you, the consumer of services, an easy and accurate means to insure that you are a full partner in your rehabilitation program.

As a consumer, you are entitled to the best services possible. One way of insuring that these services are of the highest quality is by developing a full awareness of your rights.

Eligibility, Feasibility

Prior to the start of the rehabilitation process, there must be a determination of your eligibility and feasibility for services.

Eligibility: You must have a disability that prevents you from obtaining competitive employment.

Feasibility: It must be expected that rehabilitation services will return you to work.

You are given a thorough and im-
10 partial evaluation to determine your

eligibility and feasibility for services.

If necessary, you are offered an extended evaluation of up to 18 months.

You are given an adequate medical diagnostic workup to determine the presence or absence of disability.

Your rehabilitation is thoroughly evaluated. If you are determined ineligible, you may:

Ask to be informed, in writing, of the findings as to why you are ineligible for services.

Reapply for services.

Ask for periodic review and reassessment of your ineligible classification.

Expect a periodic review of ineligibility is done at least annually.

General Rights

After you have been determined eligible, vocational rehabilitation services are offered.

The goals, functions, procedures, and operations of the agency have been explained to you.

Your rights within the rehabilitation process have been identified and explained.

The appeals process has been explained to you and you understand how to initiate this process without the fear of jeopardizing other services.

You are given a major role in the selection of services within the community.

You understand from whom you are receiving services.

You understand what these services involve.

You have been informed that acceptance or rejection of services offered will not result in the loss of other services.

Appropriate alternative services are offered when your particular needs cannot be met by the rehabilitation agency.

There are several rights that apply to

the entire rehabilitation process:

You have access to materials directly related to you which the rehabilitation counselor has gathered through other sources: Medical information; psychological information; vocational information; educational information; and training evaluations.

Confidentiality Right

The above information will remain confidential and will be passed on to others concerned with your rehabilitation only after you have signed a "release of information."

You are treated as a full partner in the planning and implementation of rehabilitation services.

You are consulted on general policy development and/or policy implementation.

The highest quality of professional attention available from the rehabilitation counselor or agency has been made available to you.

The results of contacts between your counselor and employer about your services are made available to you.

Your case is closed only as a result of joint actions taken by you and your counselor.

Individual Written Rehabilitation Plan

Your IWRP is a written contract developed jointly by yourself and the rehabilitation counselor. It is intended to establish the terms and conditions, as well as the rights and remedies, under which you are to receive services. It is designed to encourage and promote your participation throughout the rehabilitation process. It is the single more important document concerning your rehabilitation.

You have the right to approve or disapprove the contents of your IWRP; attach amendments (which will be signed by you) to your original IWRP;

(Continued on page 19.)

The Interagency Committee On Handicapped Research And The Rehabilitation Research And Training Centers: A Case Of Mutuality Of Interests

Marcus J. Fuhrer, Ph.D.

Several influential reports published during the late 1970's concluded that the federal support of research relevant to the needs of handicapped people was fragmented, dispersed among numerous agencies of government, and poorly coordinated (*cf.*, *Report of the Panel on Research Programs to Aid the Handicapped to the Committee on Science and Technology*, U.S. House of Representatives, 95th Congress, March 1978; *National Health Care Policies for the Handicapped*, the White House, 1978). In response to these and other problems, the 1978 amendments of the Rehabilitation Act created the National Institute of Handicapped Research (NIHR) and the National Council on the Handicapped. Another response was establishment of the Interagency Committee on Handicapped Research (ICHR), which was charged with the sizable mission of identifying, assessing, and coordinating all federal efforts that bear on rehabilitation research.

A purpose of this article is to describe the formative activities of ICHR.

Attempts to improve the cooperation of federal agencies with involvement in rehabilitation research are not limited to initiatives emanating from within the government. Rehabilitation research workers also may foster such

coordination as part of their attempts to obtain support from multiple agencies to undertake different aspects of a complex research effort. The Rehabilitation Research and Training (R&T) Centers of NIHR approach the problem of research support in this manner, one of their explicit objectives being to use the NIHR grant funds for work that has the potential of attracting the interest and support of other agencies. Another purpose of this article is to review the effectiveness of the RTCs in coordinating the involvement of multiple federal agencies in the centers' research and training activities.

Public Law 95-602 that gave birth to the Interagency Committee defined its objectives as follows: "The Committee shall identify, assess and seek to coordinate all federal programs, activities and projects and plans for such programs, activities and projects with respect to the conduct of research related to rehabilitation of handicapped individuals" (Sec 203 2 b). The director of NIHR is assigned the chairmanship of the Interagency Committee. The law stipulates, further, that the core membership of the committee will be composed of the agency heads or designees of the Veterans Administration, the National Institutes of Health, the National Aeronautics and Space Administration, the Department of Trans-

portation, and the National Science Foundation. Provision is made for additional member agencies as designated by the president.

The expectation of cooperative performance extends to agencies beyond those represented on the committee. The law states, "Any federal entity proposing to establish any research project related to the purpose of this Act shall consult, through the Interagency Committee established by section 203, with the Director in his role as Chairman of such Committee and provide the Director with sufficient prior opportunity to comment on such projects" (Sec i (1)). In reciprocal fashion, it is stated that the director of NIHR will consult with other federal agencies " . . . regarding the design of research projects conducted by such entities and the results and applications of such research" (Sec 202 i).

The procedures of the Interagency Committee are specified in some detail. It is required to meet not less than four times a year and to submit annual reports bearing on its principal missions to the president and to the "appropriate" committees of Congress.

The activities of ICHR can be discerned from the minutes of its formal meetings. The initial meeting in the fall of 1980 was devoted principally to introducing attendees, reviewing the

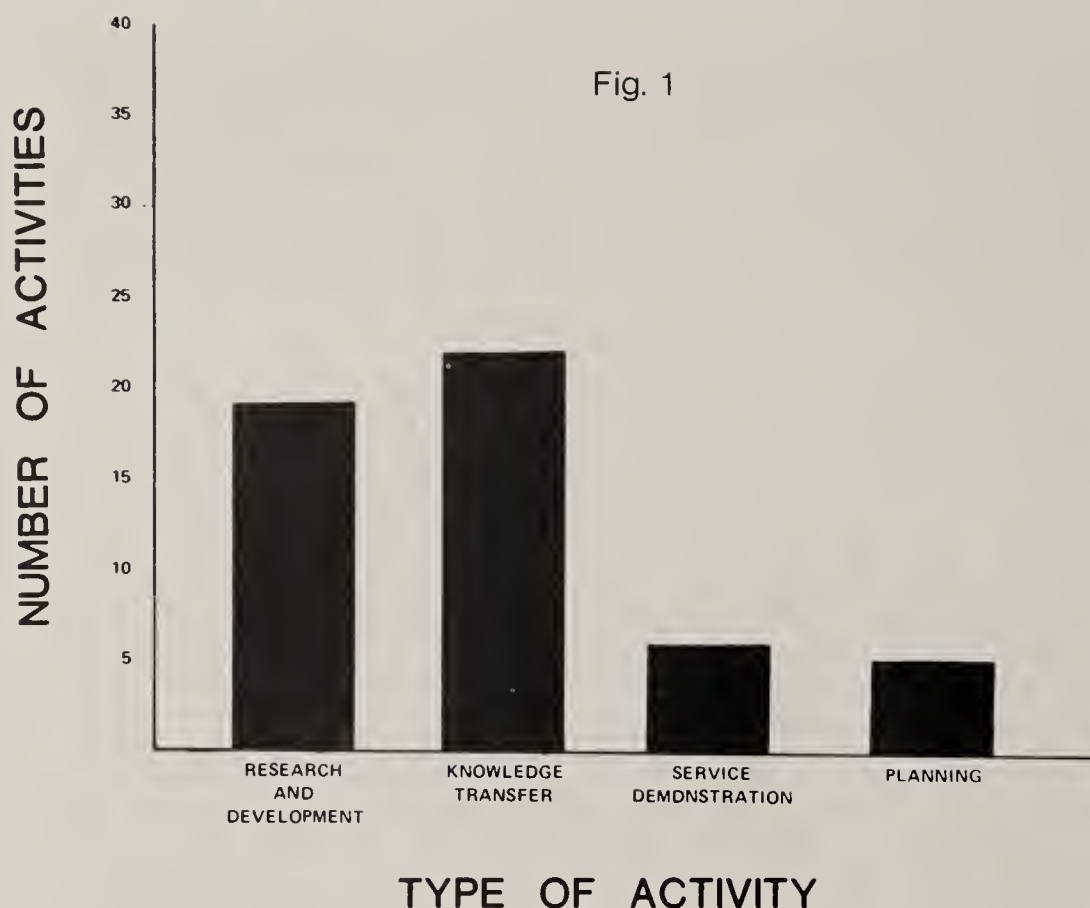
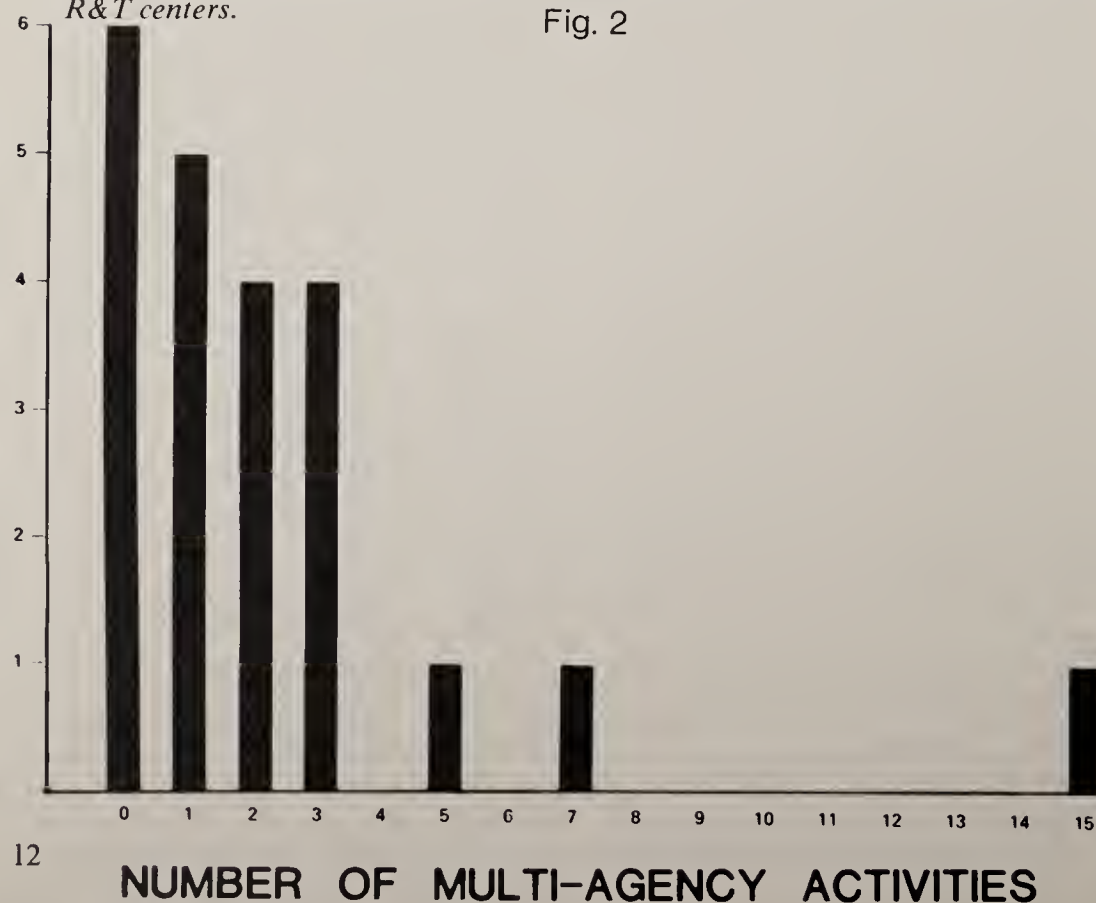


Fig. 1 Relative frequency of different types of multicenter activities among the centers. Fig. 2 Relative frequency of the 52 multiagency activities among the 22 R&T centers.

Fig. 2



committee's objectives and legislative background, discussing the definition of rehabilitation research, and considering approaches to collating information about ongoing or planning research by various federal agencies. The issue of defining the boundaries of rehabilitation research and of assembling pertinent information were discussed at the committee's next meeting in December 1980. Specific proposals also were made for developing the committee's internal organization by forming standing committees in the areas of rehabilitation engineering, medical rehabilitation, educational/vocational/psychosocial rehabilitation, information and utilization, as well as statistical and demographic data. Alternative suggestions for forming a steering committee were also discussed.

The change of administrations in January 1981 doubtlessly slowed the committee's momentum. The standing committee concerned with medical rehabilitation did hold its first meeting in March. Considerably more activity has been exhibited by the standing committee devoted to rehabilitation engineering. This is not surprising since several federal agencies have attempted to coordinate their efforts for a number of years in selective areas of rehabilitation engineering, especially prosthetics and orthotics. In monthly meetings during February, March, and April 1981, this group established meeting procedures, reviewed the relevant research being sponsored by specific agencies, and discussed a taxonomy of rehabilitation engineering research. It is notable that the March meeting of this group attracted 22 participants from 17 federal agencies.

Before continuing to comment on ICHR, it is useful to consider the collective experience of the R&T centers in dealing with multiagency activities. In March 1981, I wrote to each center requesting cooperation in document-

Table 1
Agencies Involved in R&T Center Multi-Agency Activities

Number of Activities	Name of Agency	Number of Activities	Name of Agency
2	Bureau of Education of the Handicapped	2	National Institute on Drug Abuse
1	Community Services Administration	1	National Institute of Environmental Health Services
5	Department of Defense	7	National Institute of Mental Health
1	Department of Justice	6	National Institutes of Health
2	Department of Labor	3	National Science Foundation
1	Department of Transportation	1	Office of Aging
1	Environmental Protection Agency	1	Office of Civil Rights
1	Executive Office of the President	2	Office of Human Development Services
1	Food and Drug Administration	1	Railroad Retirement Board
5	Health Resources Administration	7	Rehabilitation Services Administration
1	Health Services Administration	1	Social Security Administration
1	Indian Health Services	2	U.S. Air Force
1	National Aeronautics and Space Administration	1	U.S. Department of State
1	National Endowment of the Arts	1	U.S. Navy
1	National Highway Traffic Safety Administration	6	Veterans Administration

ing instances during the past 10 years in which other federal agencies were involved with NIHR or its predecessor, RSA, in the sponsorship or actual conduct of the center's activities. Information was solicited regarding the objectives and outcomes of each activity, its inclusive dates, as well as the names of other agencies and the nature of their involvement, *e.g.*, cofunding the activity, providing endorsements or supplying technical assistance. Comments also were solicited regarding the satisfactoriness of these activities and regarding recommended changes in policies or procedures that would facilitate cooperation. It is gratifying to report that information was received from each of the 22 R&T centers.

The following analyses are concerned chiefly with activities that were reported in effect during the 12 months ending with the first quarter of 1981. For this interval, 52 multiagency activities were identified that involved 30

different entities of the federal government. The different kinds of activities are shown in Fig. 1. Research and development efforts and what may be termed "knowledge transfer activities" (long- or short-term training courses, workshops, technical assistance, etc.) were about equally represented. There were substantially fewer instances involving service demonstrations or some type of planning mission.

The agencies that were identified and the frequency with which they were cited are shown in Table 1. It is not surprising that the agencies most frequently cited were RSA, the National Institute of Mental Health, the Veterans Administration, and the National Institutes of Health. Less predictable is inclusion on the list of the National Endowment of the Arts, the Department of State, the Department of Justice, and the Indian Health Services.

The distribution of these multi-

agency activities is shown in Fig. 2. Six centers conduct no such activities, whereas 1 reported a total of 15. The median is 1.0. The medians and ranges for the various types of R&T centers are shown in Table 2.

Changes over time in the prevalence of multicenter activities were scrutinized for the 16 centers that had been active for 9 years or more. For the period 1972-1976, a total of 58 activities were reported. For the period 1977 through 1981, the total was 81. This difference is not consistent, however, since 9 centers reported increases in such activities, whereas, 7 reported decreases.

Eleven of the respondents provided evaluative comments on some of the activities that were reported. There was unanimity that these multiagency relationships had been beneficial for their program. A particularly ringing endorsement was provided by one person who stated: "These interagency

Table 2
Prevalence of Multi-Agency Activities by Type of Center

Type of Center	Number of Centers Per Type	Median	Range
Medical	10	1	0-15
Vocational	3	1	0-3
Mental Retardation	3	2	1-5
All Others	6	1	0-3

collaborations have been absolutely vital to the development and sustenance of our program and productivity. No one agency could have afforded the support that has been necessarily 'pieced' together to achieve our objectives." Two respondents suggested that such cooperative activities will become even more important in view of the likely prospect of further cutbacks in federal funding.

Four persons cited some difficulties with these multiagency activities. Two people cited problems stemming from the agencies' different operating procedures, particularly regarding reporting. One person said, "The disadvantages are in the different types of reporting necessary and in needing to report to several different agencies about progress in each endeavor." Another commentator addressed the occasional NIHR practice of obtaining peer review not only on proposed research, but also upon continuing projects. After noting that this is not commonly practiced by other agencies, he went on to state, "We have found continuing review of projects in process, once projects have been initially approved, to be a frustrating experience. Oftentimes the reviewers' comments would have distorted the original intent of the project, as approved." Two additional comments

14 regarded problems stemming from

changes of administration in Washington. One respondent noted that these changes are associated with "... continual confusion as to priorities, lack of understanding of the program at the federal level, and a continuing change of ground rules. When we form good lines of communication and joint activities with other agencies, these are continually jeopardized by changes in Washington."

Caution must be taken in generalizing the present results. I suspect that the propensity and capability to foster multiagency activities result from specific attributes of the R&T centers, including the programmatic nature of their activities, their longevity, and their commitment to use NIHR's sponsorship as a magnet for attracting support from other sources. Thus, the present findings are more likely to apply to similar programs such as the rehabilitation engineering centers of NIHR and RSA's model spinal cord centers than to other kinds of organized programs in rehabilitation research or training.

This paper has reflected the view that efforts at coordinating the activities of multiple federal agencies toward a common goal may originate with the agencies themselves or with workers in the field, like those of us in the R&T centers. The existence of these two sources of impetus suggests the need to

clarify terminology since what an investigator or trainer perceives as a multiagency activity may not be what an agency deems as such.

This disparity is vividly exemplified by the case in which an agency may be largely unaware of the contributions it is making to a program's plan of action. For example, a medical rehabilitation researcher who is developing a new diagnostic tool to evaluate a complication of spinal-cord injury may enjoy support concurrently or sequentially from several agencies, *e.g.*, from the National Science Foundation for instrumentation development, from the National Institute of Neurological and Communicative Disorders and Stroke for animal studies, from the NIHR for developmental studies with patients, and from RSA to demonstrate use of the diagnostic tool as part of the armamentarium of a model spinal cord injury program. From the investigator's standpoint, each agency is playing a critical role in a grand design, yet one or more of the agencies may be unaware of this.

In the light of these possibilities, I would suggest that the term "multi-agency" be applied to all activities in which the contributions of two or more agencies can be seen as operating synergistically to achieve designated objectives. The term would apply regardless of whether or not the activity was defined from the agencies' vantage point or from that of a worker in the field.

The term "cooperative activity" might be reserved for that subset of multiagency activities in which there is before-the-fact intent by the agencies to join effort. In this sense, the R&T centers which are cofunded by NIHR and the National Institute of Mental Health represent excellent examples of cooperative activities.

There are numerous reasons why agency personnel and research workers

should be interested in each other's achievements in promoting multi-agency activities. Researchers are certainly interested in information that may provide clues about agencies' future priorities or about the availability of new sources of support for specified work. In attempting to achieve coordinated efforts, agencies also may provide one another with comprehensive listings of the work that each is supporting or planning to support. Such information would certainly be welcomed by researchers who are perennially concerned with the questions of who is doing what work in which place.

Similarly, there are reasons for agency personnel to be interested in multiagency activities that are identified from the standpoint of researchers or trainers. Awareness of these activities, for example, may alert agencies to opportunities for future joint planning. Agencies also may be interested in learning from workers in the field about factors which appear to inhibit or facilitate multiagency activities. Perhaps the Interagency Committee should pursue the study of these factors by conducting a survey like the present one, but expanding it to include other organized programs in rehabilitation.

Consistent with the legislatively delineated purview of the Interagency Committee, this discussion has been limited to considering activities of federal agencies. The fact remains that multiparty involvement in rehabilitation research, training, and service demonstrations extends well beyond the federal government to include state agencies and the private sector. No one disputes the potential importance of the nonfederal sources of support in view of the administration's proposals for reduced federal expenditures and for enlarged responsibilities by state government and by the private sec-

CALL TO CONVENTION '82



National Registry of Interpreters for the Deaf

Tuesday, July 27, through
Sunday, August 1, 1982
Hartford, Connecticut

Issues on the agenda for Forums, Workshops and Special Interest Group discussions include: The Political Process for Interpreters; Interpreting in Educational Settings; Interpreting in Health Care Settings; Interpreting in Criminal Justice Settings, among others.

For details:
Write Christine Stranges, c/o Connecticut Registry of Interpreters for the Deaf, P.O. Box 12202, Hartford, Connecticut 06112.

The statue of Alice, in honor of founders of the first American School for the Deaf, Gallaudet Square in Hartford. She represents all deaf children who seek light through education.



tor. Approaches developed by the Interagency Committee to increase cooperation among federal programs may well have applications to efforts to align federal, state, and private resources more effectively in meeting the needs of rehabilitation workers for knowledge generation and dissemination.

The felt need for coordinated effort is likely to grow in view of our painfully limited resources and the immense need for new knowledge to address the problems of handicapped people. The need for fruitful cooperation among federal agencies is highlighted in the long-range plan of NIHR. It is recognized in the plan that

NIHR alone will not have funds available to tackle all of the needs that have been identified. In the period 1981 through 1985, for example, it is proposed that more funds will be supplied by non-NIHR federal sources than by NIHR itself. The plan makes clear that the Interagency Committee is to figure prominently in the coordinated disposition of these funds.

Dr. Fuhrer is currently president of the National Association of Rehabilitation Research and Training Centers and associate project director of the R&T center located at Baylor College of Medicine and The Institute for Rehabilitation and Research, Houston. 15

Notes on the margin...

PASSPORT TO PARKS

Special rates on national park fees are now available to people with disabilities and their families or attendants. The National Park Service has introduced a special pass called the Golden Access Passport that will allow free access to national parks, monuments, historical sites, and recreation areas to people who are physically disabled. The Passport also provides a 50 percent discount on activities such as camping and boat launching. The special rates apply to all eligible people with disabilities and those accompanying them into the park facilities by private vehicle or on foot.

Applicants must show proof of eligibility for federal disability benefits. Complete information is available from Brian Romanek or Jim Cook, Division of Federal Lands Planning, Interior Department, 440 G Street N.W., Room 236, Washington, D.C. 20243.

MAPPING CAREERS

Two brochures are available from The Defense Mapping Agency: "Job Opportunities-- Defense Mapping Agency" and "Career Opportunities For Disabled Persons." The brochures can be ordered from Headquarters, Defense Mapping Agency, Building 56, U. S. Naval Observatory, Washington, D. C. 20305. The agency has two facilities in Washington, D. C. and facilities in Louisville, KY, West Warwick, RI, Warren AFB, WY, St. Louis, MO, Fort Belvoir, VA, and two in Fort Sam Houston, TX.

REHAB FILMS

The Rehabfilm Newsletter is a quarterly publication about audiovisual materials relating to disabled people. It is a division of Rehabilitation International of New York. Subscriptions to the newsletter is \$10. Send orders to Circulation Department, Rehabfilm Newsletter, 20 West 40th Street, New York, N. Y. 10018.

NATIONAL YEAR OF
DISABLED PERSONS

President Ronald Regan and the U. S. Congress have officially declared 1982 as the National Year of Disabled Persons. Senator Bill Armstrong (R-Colorado), sponsor of the Senate resolution, stated "This bill will intensify the national focus on the challenges and opportunities for millions of disabled Americans who have already shown they are willing and most able to accomplish things for themselves. The self-help, grassroots activities generated during the 1981 International Year of Disabled Persons and continuing through this equally important 1982 National Year, show what people in communities can do."

ACCOUNTING
WORKSHOP

Accounting for Federal Grants and Contracts, a 3-day training program to strengthen fiscal management skills. Courses to be held in August in Denver, in September in Anaheim, and in October in Seattle. For more information, contact Robert Stross, CPA, Center for Public Management, 12713 Steeple Chase Way, Potomac, Maryland 20854. Telephone, (301) 340-1610. Registration fee is \$295.

TRAVEL, LEISURE,
ETC.

Mobility International USA (MIUSA) is a new organization dedicated to expanding opportunities for disabled people in travel, leisure, and educational exchange programs. A brochure about the organization is available from Mobility International USA, P. O. Box 3551, Eugene, Oregon 97403. Telephone (503) 343-1284.

FORMER INTERNS

Attention: Former Devereux Interns and Fellows: We are trying to locate all former interns and fellows who received training at the Devereux Foundation Institute of Clinical Training in connection with a 25th anniversary commemorative brochure that we are planning. We would like to know your current address and also the addresses of any of your Devereux colleagues with whom you may have kept in touch. Please contact Dr. Henry Platt, Institute of Clinical Training and Research, The Devereux Foundation, 19 S. Waterloo Road, Devon, Pennsylvania 19333.

Deafness Awareness

As Coordinator of the Continuing Education Program at the California School for the Deaf in Fremont, Dr. Roy Holcomb supervised the writing of the test below on deaf awareness. The test is to let people know how much or little they know about deafness and to dispel misconceptions. Share it with hearing friends.

Multiple Choice

1. The number of people having hearing problems in the USA is estimated at:

- ☒ A. 4,000,000
- ☐ B. 14,000,000
- ☐ C. 40,000,000

2. Deafness is usually considered to be:

- ☐ A. a mild handicap
- ☐ B. no handicap at all
- ☒ C. a severe handicap

3. Deaf people's intelligence is:

- ☐ A. below the general population
- ☐ B. above the general population
- ☒ C. the same as the general population

4. The percentage of speech that may be lipread is approximately:

- ☒ A. 30%
- ☐ B. 60%
- ☐ C. 100%

5. Sign Language is:

- ☐ A. universal and the same
- ☒ B. differs from country to country
- ☐ C. similar to the English language

6. Fingerspelling is somewhat similar to:

- ☒ A. writing in air
- ☐ B. sign language
- ☐ C. speech

7. A 100 dB hearing loss would be considered to be:

- ☐ A. within the range of normal hearing
- ☐ B. a total loss
- ☒ C. a profound loss

8. The eyesight of deaf people is:

- ☐ A. similar to the general population
- ☒ B. better than the general population
- ☒ C. not as good as the general population

9. Deaf people can communicate on the phone via:

- ☐ A. a regular telephone
- ☒ B. A TDD (Telecommunication device for the deaf)
- ☐ C. a computer

10. Deaf people can participate more fully in conferences with the help of:

- ☐ A. good speaker
- ☒ B. interpreter
- ☐ C. good lighting

11. All deaf children can benefit from hearing aids:

- ☒ A. perhaps
- ☐ B. true
- ☒ C. false

12. Most deaf children have:

- ☒ A. hearing parents
- ☐ B. deaf parents
- ☐ C. one parent hearing and the other one deaf

13. The California School for the Deaf is located in:

- ☐ A. San Francisco

- ☐ B. Berkeley
- ☐ C. Fremont

True—False

1. Deafness is primarily a handicap of communication and language.

2. Alexander Graham Bell had a deaf wife.

3. Most deaf children are now educated in local public programs.

4. There are many administrators who themselves are deaf.

5. All deaf children should be mainstreamed.

6. Deaf children are taught to read braille.

7. "Deaf and Dumb" are proper terms to use.

8. Deaf drivers are poor drivers.

9. Hearing impaired generally means all types of hearing loss from mild to total.

10. Oral communication will help a deaf child in life more than any one aspect of learning.

11. All deaf children can learn to speak normally.

12. The most difficult subject for most deaf children to master is mathematics.

Answers To Deaf Awareness Test Multiple Choice

1. B Most surveys estimate approximately 14 million hearing impaired people in this country.

2. C Most educators consider deafness to be a very severe handicap.

3. C On non-verbal tests deaf people score on par with the population at large.

4. A In lipreading, many words are not visible and others look alike.

5. B Each country has its own system.

6. A The fingers form letters and numbers which may be made into conversation.

7. C dB measurement goes beyond 100. Anything over 90 dB is usually considered to be profound. There are very few totally deaf people.

8. C More deaf people use glasses than the population at large. Deaf people are probably more observing than others.

9. B For the last few years deaf people have been able to communicate on the phone via TDD by which they type their conversations instead of speaking them.

10. B Interpreters for the deaf are now interpreting in many settings and situations.

11. C Hearing aids are beneficial to many children, but not all.

12. A Approximately 90% of deaf children have parents who can hear normally.

13. C The California School for the Deaf was founded in San Francisco in 1860. It was moved to Berkeley in 1869 and it moved to Fremont in 1980.

True—False

1. True. Deafness hits one in many places, but nowhere as severely as with communication and language.

2. True. Not only did he have a deaf wife; but at one time, he attempted to propose federal laws to forbid all deaf people from intermarriage.

3. True. While this is true for most children, more older children may still be attending residential schools.

4. False. Outside of the residential school, there are few deaf administrators of the deaf anywhere.

5. False. Some mainstreaming may be beneficial for some children if the

proper orientation to deafness is given and interpreter-tutors are provided.

6. False. As you know, braille is for the blind.

7. False. These terms are archaic.

8. False. As a rule deaf drivers are good ones. They are more observing. They cannot listen to the radio or a back seat driver.

9. True. There are many kinds of hearing losses and hearing impaired generally includes all of them.

10. False. A good education is more important for both—deaf as well as

hearing people.

11. False. As a rule, the more hearing loss one has from birth, the more difficult it is to develop good speech.

12. False. As previously stated, English is usually the most difficult subject for children to master.

For more information on deaf awareness, write or call: Coordinator-Continuing and Community Education, California School for the Deaf, 39350 Gallaudet Drive, Fremont, CA 94538.

RIGHTS (Continued from page 10.)

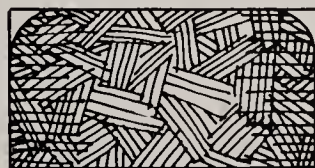
have your IWRP reviewed and/or revised annually; a procedure and schedule for periodic review and evaluation of progress towards rehabilitation objectives and goals.

Summary

To be successful in the rehabilitation process, it is most important that you understand your rights, the services you are to receive, and the contract which establishes the terms under which you shall receive these services—the IWRP. It is vital that you be

a full partner, with your counselor, in the development of your IWRP; that you express freely your feelings of its contents without concern for future services, and that you update and amend the IWRP to best suit your rehabilitation goals and needs.

The writers are staff members of the Center on Human Policy, Division of Special Education and Rehabilitation, Syracuse University. The article is reprinted with the permission of *Up Front*.

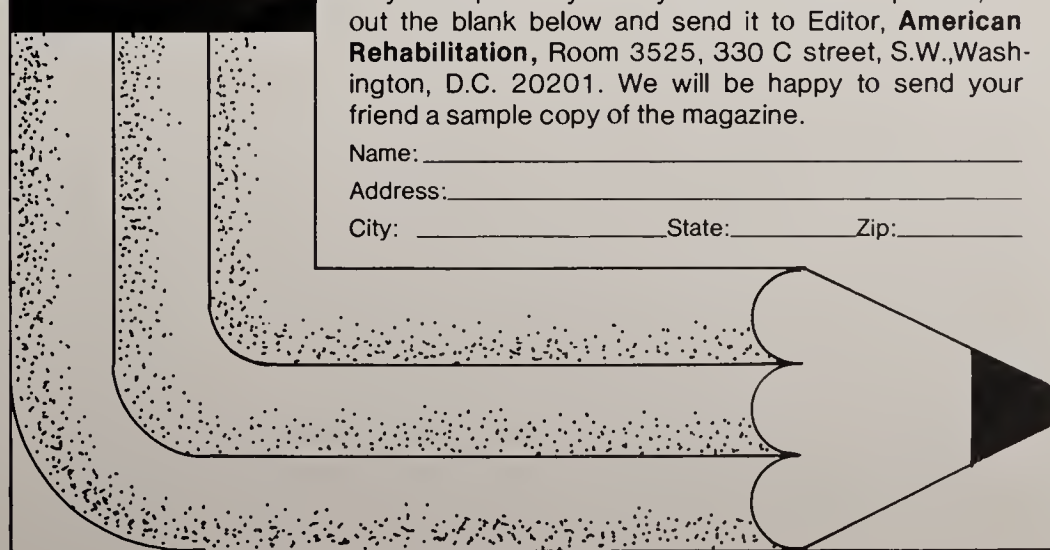


If you find in **American Rehabilitation** the kind of material that informs or that is useful to you in some way, a colleague who does not receive the magazine may also profit by it. If you know such a person, fill out the blank below and send it to Editor, **American Rehabilitation**, Room 3525, 330 C street, S.W., Washington, D.C. 20201. We will be happy to send your friend a sample copy of the magazine.

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Obfuscation is a term that defines the art of utilization of many big words on the pretext that these words are

Language Used or Used Language?

Beneath it all, we think that all of us admire people with “flair,” and secretly we wish to emulate them. But our humility most often forms the barrier that safely keeps us within the traditional boundary known as “me.” Nevertheless. . . .

If we can’t become the Oscar Wilde of society, we do compensate. Perhaps we affect our notoriety in speech and in writing: the sound of our fury brings falsetto attention to the veneer of our meaning, which is hollow and fallow (if glossed in the trappings of the spectacular). The guy in the street says it more succinctly: “We was robbed.”

Also, there are two passages from Lewis Carroll’s *Alice In Wonderland* that address this: “Only mustard isn’t a bird,” Alice remarked. “Right as usual,” said the Duchess; “What a clever way you have of putting things!” And: “‘Unimportant, of course, I meant,’ the king hastily said, and went on to himself in an undertone, ‘Important, unimportant—unimportant, important’ as if he were trying which word sounded best.”

The same source embodies the problem’s resolution. The first, in a nonsense statement: “Take care of the sense, and the sounds will take care of themselves.” But Carroll’s flair rarely allowed this dogmatic approach, so:

me he was going on a journey, I should say, With what porpoise?” ‘Don’t you mean ‘purpose’?’ said Alice. ‘I mean what I say’ the Mock Turtle replied in an offended tone.”

But the denouement to this tale probably came when a social services writer pushed Humpty-Dumpty off the wall when he heard Humpty say, “When I use a word, it means just what I choose it to mean—neither more nor less.” At that moment, intelligibility had a great fall.

Superabundance. Sue these words for nonsupport.

“ . . . resources . . . which illustrate social *adjustment experiences* that *are now available* to the *disabled population*.” When one makes a social adjustment, one has had the “experience” so that illustrations of these adjustments are already experienced. By adding an “s” to adjustment, we can experience the pleasure of honing our sentence. Likewise, “are . . . available” tells us adequately that the resources are here.

The final italicized word presents a case in style. While the word “populations” is technically acceptable, listen to the example’s euphony. Populations suggest vast, faceless crowds. A population has an impersonality. It has a coldness. Using the word “people” to replace it would warm the expression while still conveying the large number

involved. Adequate sentences can be made better and good sentences can be made to sing when word choice is considered.

Contributed *significantly*. Minimally, poorly, inadequately, half-heartedly, etc., may go along hand-in-glove with a contribution. Otherwise, don’t contribute extra baggage to this word.

. . . *me* personally. “Personally” has a sufficient amount of me in it to stand alone, *i.e.*, stand for me.

Elongationitisism. The simple form is preferred—throw rocks at rococo.

. . . live to the extent of their potential—live to their potential. Potential is capacity which includes extent. If a limit to the potential is in mind, then the word does need a disclaimer, such as living to half one’s potential, not fully realizing one’s potential, etc.

. . . provided *to selected members of the staff*—provided to some staff; in conjunction with—with; from time to time—occasionally; relative to—about; in excess of—exceeding; persons who are disabled—disabled people; assembled together—assembled.

Careful Writing. Simple writing does not necessarily mean clear writing.

When we string words together, do we always say what we intend to say? Here’s a question asked of “Dear Abby”: “Have you lived your whole life in California?” Her answer: “Not yet.”

Bureaucratic Bias (*Good words that become vogue, and, consequently, vague*). **Materials.** This word is a tag-along. We no longer write drafts, we prepare draft materials. We no longer write reports, or analyses, or plans, we submit report materials, analytic materials, and planning materials. We are living among materials that make this life of ours more and more materialistic!

“ . . . a regular weekly activity . . . ” An activity that it conducted “weekly” is “regular.”

Registration And Voting: Rights Of People With Disabilities

Kathaleen C. Arneson

As with the characters in the films on the Perils of Pauline, living effectively in a political democracy is an exercise of individual and group flexibility in the face of challenging choices. The winds of political change are always pushing the ship of state into perilous waters. Citizen legislators who steer the vehicle and scoop out the sea waters that break over it are also master social craftsmen. Our democracy has been compared to a raft which rises and falls with the action of the great waters. Other more authoritarian types of government may be compared to stately ships with heavy bottoms which move along more serenely. The people on the raft are constantly getting their feet wet when the seas are rough. But passengers on the more stately craft are likely to be drowned when the ship rams head-on into hidden rocks of dissension and controversy.

Using our knowledge that chance is a normal phenomenon and that battles won in the social and economic sectors sometimes are only temporary victories, citizens must be prepared always to justify, and then articulate and fight for their version of social justice. This also recognizes that in a pluralistic society the national habit of rising expectations of all groups is a normal and desirable goal. Shortages of re-

sources in money, manpower, technology, and materials can and are met by timely adjustments in demand. But there is no room in these maneuvers for a return to quiet, silent acceptance of discrimination, of public apathy, of covert or overt putting handicapped people back on the shelves, out of the way of notice. That time is gone. Let the past rest.

Major Questions

A major question before the national community of people with disabilities is: *How do you keep the Congress and the general public familiar with the facts about disability and its effect on individual and family?* Existing educational and advocacy efforts generally focus on the special issues of people with a single specific type of impairment such as cancer or blindness or retardation. Other groups deal with facts and problems of especially vulnerable people, such as children with disabilities or the unique needs of older disabled people. The effectiveness of these admirable efforts often fails to reveal the shape and size of the common problems shared with the total group—the 35 million disabled people whose requirements and whose coping ability varies greatly. There are some governmental programs and voluntary organizations in the country which

embrace the needs of all people directly experiencing disability. I refer to the few groups of consumer's efforts, such as the American Coalition of Citizens with Disabilities, Inc., service providers such as the Easter Seal Society through its local affiliates, and the League of Disabled Voters. These groups have special missions, of course. Thus, they engage the concern and support of people with many different types of disabling conditions; they include nonhandicapped people who work in behalf of disabled people. But their voices are only faintly heard in the clamor for public attention. Their resources are small.

A second key question is: *How do you encourage and make effective the voice of the disabled, as voters, on public issues which affect all of them directly as users of services, as taxpayers, when these services are vital to their effective functioning?*

Answers to these two questions are not too difficult to formulate. But more difficult is the task of implementation to make the attitudes of and information about disabled people readily available and usable in a timely manner. Public officials—whether in the legislative or the executive—are busy people beset with other demands and priorities. Often these public leaders are trying to carry out their duties 21

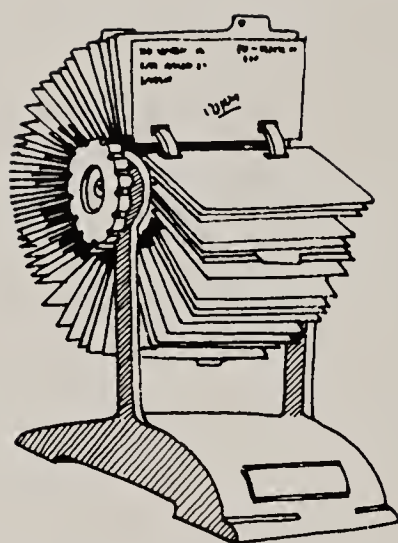
with comparatively few resources against numerous demands, their time is limited for thorough consideration of all facts and points of view about all the issues brought to them for resolution and/or legislative action.

What has been the experience of other defined groups in the body politic? They organize and they plan—in order to make their advocacy effective in policy determination and legislative action. Business interests, the unions, older people, even the producers of jelly beans—all have become adept at marshalling their cases and coralling support for their points of view.

Educational and lobbying efforts are carefully planned, usually comparatively well financed, in the light of their goals. Their action plans are characterized by

- Finely honed machinery, carrying information and suggestions from Washington and state capitals to home communities;
- Timely visits to legislators and calls to action by officers who monitor state and national legislative and regulatory developments;
- Equally timely contacts from the grassroots to the persons with decision-making authority in legislative bodies and agencies;
- Prompt assessment of the results of these efforts; and
- Communication of results to members and to the targets of their lobbying with accompanying thanks or negative criticism to those whose votes have affected the passage of substantive legislation or money bills as advocated by the group.

These examples of activity appear to imply the need for constant and careful attention to public issues before public officials. They are *not* intended, however, to obscure or substitute for the fact that both executive agency



hear directly from individuals, especially those in their own constituencies. The organization and operation of the machinery of organizational communication is for the purpose of making possible and encouraging voters or potential voters to present their views to public officials before votes on key legislation affecting the interests of handicapped people.

This ultimate objective (improved citizen communication to his representative or senator, or to his local or state agency director) is the key to improved functioning of representative government by and in behalf of disabled citizens. It is expected that legislative and executive leadership of government will benefit by this communication in at least two ways:

- The real impact on the person of proposed courses of action can be assessed by sampling the viewpoint of the intended beneficiaries of that action. (This is a natural extension of the congressional hearing concept where leaders of consumer groups often testify in this manner.)
- The strength of general public response to the drift or direction of policy on broad social and economic issues can be gauged more readily.

Handicapped and other people are becoming more aware of the effect on them and their families of the govern-

ment's definition and solution of the country's social health or economic problems. Interest rates, cuts or increases in taxes, deferments in federal funding of laws, recisions or changes in amounts of funds available—all are becoming better known as ways to reduce or withdraw the benefits or protection of government. And these actions at once are shown to be keys to the relative health, education, and general economic status of the people in our society. These are crucial in a society which uses national and local government to achieve acceptable balances in societal benefits through shifts in income or preferences determined by legislative judgments acting to ameliorate the negative fall-out of relatively unfettered, free enterprise efforts.

One does not have to approve or deplore this process which translates into changes in group benefits, to recognize the value of being able to identify and then to organize to express and protect one's interests. Business and professional groups, veterans and union groups, and the general citizenry itself has become conscious of the need for effective organization in the political arena. It seems that there are now PACS for all but the cobbler's son—political action committees. In addition, women have the League of Women Voters to educate their new cohorts; LULAC serves voters of Latin origin; other leagues and associations to advance groups and to educate and mobilize them and the general citizenry have preceded the formation of the new League of Disabled Voters.

Was it correct to introduce another group into the arena of voting? Many of us think its formation was necessary and timely, as a complementary body to partisan political bodies. Others find no need for it, preferring to express their voting rights and interests solely through established Republican,

Democratic, or nonpartisan political committees. They find these sufficient along with access to public opinion making through existing special interest groups such as those for civil rights, health reform or generic groups to improve the voting climate, such as projects of Common Cause.

Whatever the merits of any one of these approaches, a group of disabled persons organized a League of Disabled Voters 2 years ago. Their public information brochure explains the nature and objectives of the group. (It is given in a question and answer format and may be requested by writing League of Disabled Voters, P. O. Box 23283, L'Enfant Plaza Station, S.W., Washington, D.C. 20024.)

Next Year's Priorities

The first year, a national board of disabled volunteers devoted itself to getting organized and assessing its limited role within the larger group of organizations of and for handicapped people. It strove to act in effective ways to let candidates for national presidential office know that they must be accountable to a constituency with disabilities as well as to other groups.

The second year, 1981, the League board and its volunteer legislative liaison concentrated on informing legislative offices in Washington of its existence and of its concerns. Through work with coalitions of groups, expressions of fact, concern and support were conveyed to legislators and administrators developing proposals to alter programs or existing levels of service to disabled people. A few timely bulletins alerting members to issues and alternatives were released. These were used in letters and calls to congressional offices. Information, on request, was sent to people calling and writing for information about the League or one of the issues to which it was giving attention.

In 1982, emphasis to date has been upon the development of policies and procedures to enable people with handicaps to have access more readily to sites where registration and voting in federal elections take place. A coalition of major organizations of handicapped people, general public issue and public policy groups, civil rights and union groups has been working with members of the Congress to lay out essential features of proposed federal legislation to assure that handicapped people can register and vote in federal elections.

Based upon a proposed bill, introduced during last year's Congress by Mr. Hamilton Fish of New York, work has been concentrated on improving and simplifying suggested procedures that are intended to expand registration and voting opportunities.

By the time this article is printed, Mr. Fish and other members probably will have introduced their bills on voting accessibility. The debate will be underway. The closeness of 1982 and 1984 elections gives special urgency to the efforts to enable the electorate to participate in greater numbers in important tests of choosing leadership.

We who have spent years in advocating fuller participation by people with disabilities in the decisionmaking

processes which affect them, see this new effort worthy of your attention and support.

The originators and leaders supporters of the League include people like Durward McDaniel of the American Council of the Blind, Al Pimental of the National Association of the Deaf, Eunic Fiorito, national advocate; Frances Lowder of the National Association of the Physically Handicapped; Reese Rohbran, now executive director of the American Coalition of Citizens with Disabilities, Inc., Dick Hedinger, transportation advocate, and George Conn of the Paralyzed Veterans of America, now serving as Commissioner of the Rehabilitation Services Administration. Members and other leaders cross the entire variety of disabilities and ages and interests.

More than 20 national organizations are now working with the LDV on voting accessibility. We join others on saving social security for disabled people. This mutual reinforcement is a most valuable consortium.

Write to the League for membership information (\$10 annually) and facts on the issue of accessibility to the ballot box. More important, make your congressman and senators aware of your place in their home constituencies. Give him the benefit of your experience as a person with disabilities. Let him know of your willingness to provide him with local information and support when he takes leadership on handicap issues.

The importance is great of your speaking up, speaking out—clearly and factually and with fervor about what it means to be disabled in America today.

Mrs. Arneson is a consultant in rehabilitation and legislative liaison for the LDV. For 20 years, she was legislative director and congressional liaison for RSA.



PUBLICATIONS & FILMS

Psychological Evaluation of Hearing Impaired Children and Adults. 20 min. Color. Sound. 16 mm. Lori Smith, Film Distributions, Boys Town Institute, 555 North 30th Street, Omaha, Nebraska 68131. (402) 449-6511

The Boys Town Institute for Communication Disorders in Children has produced this film on the psychological evaluation of deaf children and adults. It and appropriate supplementary literature will be made available on loan, at no charge, to professionals and other interested parties. The film received the award for Creative Excellence in Medicine and Health at the U.S. Industrial Film Festival, 1981.

The Chronic Mentally Ill. Treatment, Programs, Systems. John A. Talbott, M.D. Human Sciences Press, Inc., 72 Fifth Avenue, New York, N.Y. 10011. 374 pages. \$32.95.

Compiled by leading authorities in the field of mental health, this book offers a broad spectrum of care and treatment modalities for the chronic mentally ill. The most significant forms of treatment are described, including psychopharmacological therapy, medication monitoring, psychotherapy, socialization, housing, case management, and vocational rehabilitation.

Contributors examine effective services and programs emanating from a variety of sources, such as nursing homes, state hospitals, private practitioners, general hospitals, community agencies, and Veterans Administration Hospitals.

Specialized programs for children, the elderly, and rural populations are described in detail. In addition, three state and county service systems which attempt to cope with the massive after-

math of deinstitutionalization are examined. This book will be of value to psychiatrists, psychotherapists, psychopharmacologists, administrators in psychiatric and human service organizations, and related health professionals.

Selected Aspects of Financial Management In Rehabilitation Facilities: A Resource Manual. Jerome R. Lorenz, Chris S. Graham, and Patsy L. Hashey with contributions by Richard J. Baker. Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin, Menomonie, WI 54751. \$18. (National Association of Rehabilitation Facilities members, \$14.)

The manual is designed for rehabilitation facility administrators to improve their knowledge and upgrade skills in selected aspects of financial management. Each chapter introduces a new topic of concern on financial management, gives basic principles, provides an example, and allows the reader to test his knowledge of the topic via a practice exercise.

Covered are organizing a fiscal management function, internal and external fiscal control, budgeting, accounting, and fiscal analysis.

Annual Review of Rehabilitation. Volume 2, 1981. Elizabeth Pan, Ph.D., Thomas Backer, Ph.D., and Carolyn L. Vash, Ph.D. (editors) Springer Publishing Company, 200 Park Avenue South, New York, N.Y. 10003. 305 pages. \$38.

Eighteen authors contribute to its 11 chapters which deal with service and research in mental retardation, disincentives, followup studies, sexuality, placement, epilepsy, rehabilitation

facilities, cerebral palsy, case management, organizing and delivering rehabilitation services, and agency program evaluation.

Vocational Preparation of Persons With Handicaps. Second Edition. Donn E. Brolin with contributions by James C. Brolin. Charles E. Merrill Publishing Co., Columbus, OH. 43216. 360 pages. \$17.95.

This is a well-put-together, well-presented perspective of programs, policies, legislation, and services affecting the Nations disabled citizen. Each chapter is epitomized under the rubric "Points to remember" and presents a list of suggested readings. It is indexed by name and subject, has a complete reference section, and is liberally illustrated with photographs, charts, and tables. Marginal annotations are clever and directive.

Its four parts cover background materials (vocational services; handicapping conditions; vocational development, maturity, and outcome; and vocational preparation), vocational evaluation, vocational development, and program models.

Disabled People At Work And Play. Norman H. Ludlow, compiler. Human Sciences Press, 72 Fifth Avenue, New York, N.Y. 10011. 64 pages. \$15.95, plus \$1.63 shipping and handling.

Newsletter editors are all familiar with the "nagging little holes" at the end of an article for which a type filler cannot work. This publication offers hundreds of line drawings in various formats that can be used to plug up the holes while adding a bit of variety to the printed page. (Editorial note: all of the illustrations are line drawings, but we would have liked to have seen some definitive life drawings, say in charcoal or pencil sketch.)

All of the drawings are on the right hand pages so that cut outs do not ruin subsequent presentations. The artist for all of the sketches is Sheila K. Devine.

Every major handicapping condition is represented, often by a selection of several sketches in different size renditions. (Editorial note: a relatively random presentation of the sketches makes a swift location of the needed spot unduly difficult. The book could have been improved by subject classification or by indexing.)

Systems Of Treatment For The Mentally Ill. Richard E. Gordon and Katherine K. Gordon. Grune and Stratton, Inc., 111 Fifth Ave., New York, N.Y. 10003. 376 pages. \$34.50.

This book describes comprehensive programs of services that augment traditional methods in the treatment and rehabilitation of the chronically ill child, adolescent, adult, and elderly mental patient. The authors show how to integrate medical, psychodynamic, and behavioral techniques with modular psychoeducational and peer support methods, so that patients learn the personal, social, and vocational skills that enable them to cope better with their problems and reduce their need for institutional care and treatment.

The services described include management of the acute manifestations of mental illness, time-limited hospital treatment for controlling the early stages of illness, and modular psychoeducational and peer management inpatient programs that help overcome basic skill deficits as well as the effects of repeated institutionalizations. The authors also discuss training for placement in community living facilities, preparation for participation in community peer support networks, and development of

aftercare programs that maintain and enhance patient gains from residential treatment.

The book demonstrates how paraprofessionals, patients, and families can learn to care for patients' unmet service needs and how mental health professionals can supervise and monitor combined treatments for hospital inpatients and, when needed, provide consultation and professional care in community programs for enhancing outpatient skills and supports. The book will help mental health administrators and policy makers implement these combined treatment methods in their own mental health systems without major new expenditures of additional funds. It will also aid program directors in establishing an atmosphere of high morale, strong motivation, and good cooperation among all levels and disciplines of staff.

The Day Hospital. Organization and management. Charlotte M. Hamill, editor. Springer Publishing Co., 200 Park Ave. South, New York, N.Y. 10003. 177 pages. \$23.50.

When The Burke Rehabilitation Center Day Hospital began in March 1973, it was one of four research demonstrations funded by the Department of Health, Education, and Welfare. Its major focus was the development of a comprehensive rehabilitation treatment service appropriate to the needs of physically impaired elderly patients who wanted to continue living in the community. Throughout the initial demonstration period and in the years since then, the need for specific information and guidelines has become increasingly apparent.

This handbook provides the basic information and guidance needed to initiate a day hospital program. It describes the process and the services in sufficient detail to give the potential

sponsor an overview of what is involved. Any successful program undertaking, however, will need to be tailored to meet specific local needs and to qualify for current local reimbursement.

Policy Planning and Development in Independent Living. University Center for International Rehabilitation, Michigan State University, D-201 West Fee Hall, Lansing, Michigan 48823. \$3.50.

This monograph is a report on the proceedings of a short-term workshop. The training program, sponsored by UCIR under a grant from Federal Region V, addressed two high priority training needs of the Region V state rehabilitation agencies: policy analysis as a dimension of program and financial management and development of independent living services as specified in Title VII of the Rehabilitation Act, as amended.

The overall goal of the 2½ day program was to assist states in the development of appropriate and effective independent living rehabilitation programs by increasing participants' abilities in policy planning and development. Approximately 40 state agency people attended. Participants were selected by each agency based on their involvement in policy planning and development, and/or independent living services.

The proceedings present a model for implementing policy planning and development in the design of programs which will be harmonious with the historical perspectives of the independent living movement. Materials are arranged in a sequential manner which simulates the actual training process. The document also includes an overview of a variety of independent living experiences, a resource bibliography, and a glossary of relevant terminology.

Women And Disability

Kathleen Lloyd, M.D.

This is the first part of a project on Women and Development inspired by the International Year of Disabled Persons and sponsored by the Joint United Nations Information Committee. The kit is a collection of information and quotations written by disabled women themselves and many who have worked with them throughout the world. It was produced by a number of cooperating organizations and is being distributed by the International Labour Organization, CH-1211, Geneva 22, Switzerland. It is to be followed by a second kit which will focus on Women, Health, and Development.

The objective is to help "women with disabilities to achieve full participation and equality." It is hoped that the kit will help groups or organizations to develop programs which will help to change unproductive attitudes towards people with disabilities and provide a more accepting society, as well as to prepare the population with disabilities to take their rightful place in their homes, in society, and in the work-world.

The kit is divided into five parts which enable one to separate out one section at a time, or to allocate different sections to several groups.

Part I covers objectives, definitions and suggestions for use. Part II deals with a disabling world, including extent and cause of disability and how women are particularly affected. Part III describes "the poorest of the poor," education and work (or lack of work) for

disabled women, marriage, child care, social and psychological factors and special legislation; IV is concerned with prevention, rehabilitation and social reintegration; V lists organizations, written articles and audiovisual material pertinent to the subject.

It is hoped that the kit will help to bring to the attention of people and governments the situation of disabled women and the prevalence of disabled persons in impoverished populations. This also seeks suggestions for ways of combatting poverty, disability, sex discrimination, and cultural and social barriers which prevent women from functioning fully in society, in the world of work, and in their own communities.

The statement is made that 10% of the world's population is physically, mentally or sensorially disabled and that a high percentage of these are poor and/or females. In this country we tend to be unaware of the tremendous effect of poverty as a contributing cause of disability. In some of the poorer areas of the world, malnutrition, vitamin deficiency and lack of sanitation can cause overwhelming problems especially for the female population which often is held in low esteem. Certain traditional occupations may cause excessive stress, overexertion, eye strain, or may lead to functional impairments. Pregnancy is an added hazard for the mother of the family, especially when it occurs at too-frequent intervals. Religious customs and traditions may also lead to the development of disabilities. And, finally, social customs and attitudes, especially those involving women, can change a simple impairment into a major disability. While many of these contributing causes happen to both sexes, they are particularly devastating to females where that section of the population is held in low esteem or even considered second class citizens.

Education of females is frequently inadequate. The male is considered as the head of the household and as such receives a better education. This, of course, leads to less opportunity for the female to find adequate employment or compensation whether able-bodied or disabled.

While prevention of disability and good primary health care are important for the maintenance and improvement of the quality of life in any community, little attention is paid in many instances to health education or immunization programs for either males or females. It is pointed out that rehabilitation is scarce and hard to come by in developing countries. Improving rehabilitation services and increasing such facilities would provide a big step forward in these areas. Improving education would help to upgrade the social position as well as increase employment opportunities for women. It is most important that families be included in any rehabilitation activity since it is only with their understanding and cooperation that any lasting changes can occur.

This kit also provides success stories and "how to" examples in different circumstances and with different disabilities. Pertinent references and resources are provided in Part V: a bibliography, list of organizations, etc.

If this kit is widely distributed and used, it should contribute much to the upgrading of disabled women not only in developing countries but also in the industrialized world. One must remember, however, that social and religious customs and prejudices are deeply ingrained and difficult to alter; before discernible results are evident, there must be sustained efforts to improve the condition of women and especially women with disabilities.

Dr. Lloyd is a medical officer with the Rehabilitation Services Administration.

Sign up for 'Signing'



"Signing" is one of the principal ways deaf persons communicate.

If you can learn the language of signs, you can speak with most persons with long standing severe hearing problems and help end isolation and broaden their horizons. And your own.

Often persons with hearing problems do not know about basic services within reach in their community because of the inability of most social workers to communicate with them.

To obtain information about courses on signing in your area, contact a local vocational rehabilitation office, a club or school for the deaf, or a hearing and speech agency.

NEWS, NOTES, ANNOUNCEMENTS



Handicapped Man Sets Aircraft Records

Abilities Demonstrated By The Disabled (ADD) announced that pending approval by the FIA and the National Aeronautics Association, ADD has established 14 world and national records in the ultralight airplane class. The record flights are part of ADD's program to publicize the abilities, talents, and skills of disabled people.

Zane Eldo Myers, 47, of Bella Vista, California, a former teacher and fireman who is now retired with a severe back injury, piloted the aircraft. Wizard of Pompano Beach, Florida, donated the two aircraft in which land and seaplane records were established.

It is especially appropriate that a disabled pilot hold the ultralight records because a large number of handi-

capped fly ultralights. Without the ultralight class and its lack of restrictions, many would never know the freedom of flight and its symbolic victory over their handicaps.

So far ADD and Zane have set 14 world and American records. Most of the records were set near the Salton Sea.

Physically, the flights were not easy for Zane, whose back problems are aggravated when he sits or uses his hands and arms in front of his body, and both such positions are required to fly the airplane.

The records involved such things as distance on a closed course and in a straight line and speed runs for measured courses, both on land and at sea.

If more information is desired, call Zane Eldo Myers at 714-593-3777 or write to him in La Verne, California.

Hartford Site For Interpreter Meeting

The National Registry of Interpreters for the Deaf (RID) will hold its 1982 convention in Hartford, Connecticut, July 27 through August 1, at the Sheraton-Hartford Hotel.

The convention program is an ambitious one which addresses the problems of deaf people and the people who interpret for them in every aspect of community life, including, among others, political process, education, counseling, and rehabilitation.

For further details, write RID Convention, Christine Stranges, Chairman, c/o Connecticut Registry of Interpreters for the Deaf, P. O. Box 12202, Hartford, Connecticut 06112.

Disabled Youth Target Of Job Training In Mass.

The Electronic Industries Foundation (EIF) has announced a project to enhance job skills training for disabled and disadvantaged high school students through linking vocational education programs with high-tech electronic companies.

Tagged JET, for Jobs through Education and Training, the new program will be directed by Victor C. Knorr, EIF Program Manager.

Support for the program is provided by the U.S. Department of Labor's Employment and Training Administration, Office of Youth Programs, through the Institute of Economic Development, a Washington-based,

nonprofit corporation which provides a variety of services to communities to assist them in expanding job opportunities and encourage economic growth.

The program will be conducted in Massachusetts where EIF's successful Project With Industry is already in operation. Project With Industry seeks to place disabled people in jobs in private industry and also includes a component for training solderers, assemblers, and technicians specifically for jobs in electronics.

Deaf-Blind Studies At Western Maryland

Western Maryland College, in conjunction with the Helen Keller National Center for Deaf-Blind Youths and Adults in New York, is offering the first academic programs ever provided to prepare applicants for a career in the field of work with deaf-blind adults. The Master's program consists of a core of 18 graduate hours in the fields of deafness, blindness, and deaf-blindness. Another 9 hours will be spent in a field of emphasis, selected by the student from areas including mobility training, administration, reading, physical education, secondary education, or special education. The remaining 6 hours will include a course in research and one in the liberal arts.

Academic work is followed by a one semester, individually designed internship at the Helen Keller National Center.

Scholarships are available for a limited number of students, and there are other sources of financial aid.

For further information write Office of Graduate Studies, Western Maryland College, Westminster, MD 21157 or call (voice and TTY) 301-848-7000.

Gazette Publishes 24th Edition

The *Rehabilitation Gazette*, a nonprofit international information service and journal for independent living by disabled people, published its 24th annual issue. The magazine goes to readers in 84 countries.

The new issue provides 64 pages of specialized information for people with all types of disabilities, for the professionals who work with them, and for the institutions that serve them.

Features include a report on the International Conference on Respiratory Rehabilitation and Post-Polio Aging Problems, a compilation of creative experiences with independent living, pain control through self-hypnosis, coping with the problems of hospital care, hoists, VA-tested van lifts, and female sexuality.

Copies may be ordered from 4502 Maryland Avenue, St. Louis, Missouri 63108. Price is \$4.50 for disabled people and \$7 for nondisabled, plus \$1 postage.

Braille Consumer Pubs Available In English, Spanish

The Los Angeles County Department of Consumer Affairs has announced that three of its consumer information fact sheets are now available in Braille—in both English and Spanish.

The three pamphlets are: "There isn't always a Law," dealing with self protection in the marketplace; "Help Yourself Become a Wiser Consumer," which gives eight tips on how to avoid being taken in by unethical business practices; and a

step by step instruction sheet on making complaints against unfair treatment or shoddy merchandise.

The Braille publications can be ordered from the Los Angeles County Department of Consumer Affairs, 500 West Temple Street, Room B-96, Los Angeles, CA 90012 (Phone 213-974-1452, Voice). Requests should specify either the English or Spanish version.

"Consultation" Is New Publication

"Organizational consultation involves a professional service of providing information, advice or help to an organization in meeting its objectives or solving its problems." Or: "A consultant is someone who borrows your watch to tell you what time it is."

Consultation is defined and viewed in many different ways by staff of mental health agencies and other human service providers. CONSULTATION, an experimental publication sponsored by the National Institute of Mental Health, aims to become the hub of a communications network for the growing field of organizational consultation in the human services.

CONSULTATION is published three times a year and is free to subscribers who work in mental health and related fields. The publication is part of a larger project, the Consultation Research Program, which is codirected by Drs. Edward M. Glaser and Thomas E. Backer. For details, please contact Meg Grant, Consultation Research Program, Human Interaction Research Institute, 10889 Wilshire Blvd., Suite 1120, Los Angeles, California 90024.

Mumps and Hearing Loss: An Overview

McCay Vernon, Ph.D., and Carol Huatt

Before a vaccine for mumps first became available for general use in December 1967, the disease was contracted by approximately 80 percent of Americans.¹ Immunization has reduced the prevalence of this illness to about 20 percent today, but it remains one of the most common examples of a virus associated with sudden deafness.²

One problem related to prevalence data on mumps and deafness is that the disease is sometimes hard to diagnose. About 30 to 40 percent of infections are subclinical, making their presence difficult to detect and the virus hard to trace.³ The end result can be severe after effects because of lack of early or appropriate treatment.

When mumps affect hearing, the loss is usually unilateral but occasionally bilateral. Overall, about one in 15,000 cases of the disease results in hearing loss.^{4 5} This figure is tenuous because of other problems that may occur after the onset of mumps, e.g., meningitis, which is a proven cause of postnatal deafness in young children.⁶ Thus, many youngsters with their etiology of deafness listed as meningitis may have actually been deafened by subclinical mumps.

realize the importance of a hearing test for a person who has had an attack of mumps. A "simple" mumps infection may result in auditory complications affecting a full lifespan.

Nature Of The Disease

Mumps is caused by a large RNA virus called myxovirus parotitis. It occurs more frequently during the cold seasons, especially late winter and spring. Until the vaccine was developed, epidemics tended to occur every 7 to 8 years. The illness affects both sexes equally, and it is found in all parts of the world. Children under the age of 15 years account for approximately 85 percent of infections.^{7 8}

The virus is transmitted by direct contact with the saliva or droplet spray of an infected person. However, it is not as highly contagious as chicken pox or measles. The incubation period is usually 14 to 21 days, from time of initial exposure. Symptoms include a fever that can range from 101° to 104° Fahrenheit, accompanied by chills, headaches, a loss of appetite, and pain under the ear. Vomiting is sometimes present. Over a 24-hour span, there is a gradual swelling of one or both of the parotid glands in front of and below the ear. The face becomes puffy, and

eating is painful. These symptoms disappear within 7 to 10 days.

Usually diagnosis is relatively simple and based on observance of the symptoms. However, when clinical manifestations are confined to the less common lesions, diagnosis is easily missed. The most certain way to make the diagnosis is to isolate the virus from saliva or cerebro-spinal fluid and use seriological tests. As indicated earlier, a failure to make the correct diagnosis may lead to faulty treatment. This, in turn, can result in severe after effects.

One of the main complications of mumps, meningoencephalitis, occurs when the virus penetrates the meninges. Other complications can include testicular swelling and tenderness; inflammation of the ovaries, pancreas, breasts, or heart muscles; arthritis and cranial nerve damage.⁹

Mumps And Hearing Loss

Deafness caused by mumps is usually of sudden onset. Hearing loss is severe, but may improve over time.¹⁰ Tinnitus is a common feature along with possible vertigo.^{11 12} Although hearing loss is usually unilateral, almost 20 percent of reported cases affect both ears.¹³

Lesions From Mumps

Different studies have suggested several explanations of how the virus causes deafness. Some researchers feel that it enters the upper respiratory tract, goes through the bloodstream, then moves to the glands and nervous system.¹⁴ Once in the bloodstream, the auditory artery (the only blood supply to the cochlea) may become blocked by a red or white blood clot, resulting in unilateral deafness.

Another way deafness could be caused is from inflammation of the labyrinth. Prasad¹⁵ reported a case of an 11-year-old boy who lost his hearing 14 days after mumps onset. Involvement of both labyrinths was apparent when both ears were syringed with 5° C of water and no nystagmus could be produced. Prasad felt that either a hemorrhage or an escape of fluid, cells, and cellular debris from blood vessels occurred as a result of inflammation.

Another explanation of how mumps causes hearing loss is related to meningoencephalitis. It may bring on a coma or a paralysis and can destroy brain tissue. In association with this, an inflammation of the eighth cranial nerve may occur resulting in deafness.^{16 17 18}

Mumps infection is also thought to invade the inner ear through the Eustachian tube and middle ear.¹⁹ Once the virus reaches the inner ear, several changes may occur which essentially involve the degeneration of the organ of Corti.²⁰ More specifically the capillary network in the cochlea atrophies, causing destruction of hair cells.

Sawada²¹ used electrocochleography to study the site of lesions in mumps deafness. They found three different forms. In one, neural regions were impaired, such as the nerve fibers and hair cells, but the organ of Corti still function. In the second type of deafness, the neural regions were impaired and the organ of Corti only par-

tially impaired. In form three, both the neural regions and the organ of Corti were found to be severely damaged.

Age Of Onset

The younger the child contracting mumps, the more likely a severe hearing loss. However, the mumps-deafened, school-age youth generally has a later onset of hearing loss and one that is less severe than that of the general population of hearing impaired children. Thus, a lower percentage of these youngsters require full-time enrollment in special education programs.²²

However, like any type of childhood hearing loss, there can be detrimental effects in many areas including impaired learning at home, in school, and in social settings. It cuts down on the variety of ways of communication, not only in conversation, but also television, radio, and reading.

Prevention by vaccine is vitally important. Mumps is not just a "simple" childhood disease. It can strike adults, as well as children, with a crushing blow—deafness.

Dr. Vernon is Professor of Psychology, Western Maryland College, Westminster, Maryland. Ms. Hyatt is a counselor at the California School for the Deaf, Fremont, California.

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An Appeal To Reason

The following was submitted to *American Rehabilitation* as a news release in the form of a Letter to the Editor, written by Jane Small Sanford of the Comprehensive Rehabilitation Center, Inglewood, California. What is it, anyway? It is a statement of fact (sobering). It is an editorial. It is an appeal (but not for direct funds, but for the currency of commitment). It is a sociologic report. It is a call to reason. Finally, it is something that we would like to share with you. . . . **Editor.**

Dear Editor:

Over 40 million people in this country have some kind of physical condition that limits our full participation in society. In reality, it is not our physical condition that limits our participation, but the world that you, the able-bodied, have created; a world that excludes all but the most able-bodied people. To think of this as an issue for only a limited number of people is deceptive. While at any given moment the number of people with severe physical disabilities is finite, in the long run almost every member of our society will be counted in our number.

In the world of disabled people we call the rest of you TABS, Temporarily Able-Bodied. Given the statistics on longevity and accident, that is what you truly are. We raise the spectre of your own frailty. We jeopardize your collective image of what is desirable in life. We create in you a feeling of guilt at your own, as you see it, inability to "heal" us. It is not "healing" that we require, but rather acceptance of us as we are—acceptance of us as valuable and *able* contributors to the community.

Perhaps the greatest barrier to our full participation in the community is the mind set of those around us. All too often we have either been overprotected or completely ignored. What you must recognize is that when we demand acceptance, when we ask to be allowed to participate fully, we are also asking to be allowed to succeed or to fail, as the case may be.

Last year, throughout the world, countries and communities observed the International Year of Disabled Persons (IYDP). Last year, some among us were singled out for honors; certain employers were commended for hiring us, songs and poems were written in our honor; posters immortalizing us and stamps and coins com-

memorating us were issued by cities, countries, provinces, districts and nations everywhere.

Yet, this year, we are still being denied access to the community—we are still unaccepted as an integral part of society—we are still being under-utilized and our potential for productivity is still unrecognized by most of those around us. This year, in this country, we are facing the loss of programs that for many of us have been the first step toward that acceptance and that participation we do desperately want and need.

What then did IYDP really mean? Did it denote the end of an era of progress for persons with disabilities? Or can we, working together, ensure that it will be remembered as a beginning, as a time when all of us, private sector and public sector, individuals and governments, joined together creatively to make true acceptance and true accessibility a reality.

No people anywhere have the dynamics and the energy and the creativity found here. No people anywhere have a deeper commitment to public responsibility. Nowhere else is there such potential for success.

We who have disabilities are willing to accept our responsibility in playing a greater role in determining and shaping the policies and programs that will make our full participation in society a reality. We are willing to recognize and accept the limitations of the public budget. We are not willing to accept an end to the progress we have made toward full integration within the community.

We who have disabilities have designated 1982 as *International Year of Disabled Persons—Plus One and Counting*.

Together, creatively, we must find the means to fund those programs that enable us to live in the community, recognizing that such programs are far more economical and cost effective than the high price of institutionalization, a nightmare that hangs over many of us always.

We are ready to join with you in building toward a better tomorrow for all of us. We ask you to join with us in enabling our lives to be as full and productive as possible. Only then will the International Year of Disabled Persons have had any meaning. Only then can it be remembered as the beginning and not the end.

We are counting.



July-August 1982

AMERICAN REHABILITATION

Mary Switzer
Seminar
Women and
Rehabilitation





Yes I can

My most wasted days
were those feeling sorry for myself.
I know where I'm headed now,
and that's a good feeling.

AMERICAN REHABILITATION

Volume 7, Number 6

The weakest ink is better than the strongest memory.

July-August 1982

5 Utah Program Trains Mine Workers

Karl F. Kraync

8 Preparing Manuscripts For Publication

Ansa Ojanlatva

12 Rehabilitation Information

Eleanor L. Biscoe and
Mark X. Odum

18 Independent Living And Learning
Disabled Adults

Dale Brown

23 Women And Rehabilitation

Kathaleen Arneson

30 1981-82 Index

DEPARTMENTS

2 Topic of State

4 Language Used

15 New Publications

16 Notes On The Margin

29 News, Notes, Announcements

U.S. DEPARTMENT OF EDUCATION
T. H. Bell, Secretary

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES
Jean S. Tufts, Assistant Secretary

REHABILITATION SERVICES ADMINISTRATION
George A. Conn, Commissioner

Ron Bourgea, Editor Barbara Pegram, Assistant

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Paid subscriptions are accepted (see Cover IV for blank). Correspondence concerning paid subscriptions should be sent to Superintendent of Documents, P.O. Box 1533, Washington, D.C. 20402.

TOPIC OF STATE

Computer Assists Cal. Counselors

Rehabilitation counselors in the California state agency now have a new tool to help them serve clients better: VOCOMP, a computerized counselor assistance system that can identify vocational and training options for disabled clients throughout the state. The California Department of Rehabilitation recently purchased the VOCOMP system from Innovative Software, a Los Angeles-based firm which develops information technology for the human services.

The VOCOMP system will help save California counselors thousands of hours every year in the research they do to identify job or training opportunities for their clients. In many cases, the computer can identify some options, from the thousands available, that a particular counselor might not even know about.

The VOCOMP system is already in use by many private rehabilitation agencies and insurance companies. A number of other state rehabilitation agencies are now field-testing VOCOMP for possible adoption during 1982.

Over the last few months, counselors from all over California have been trained in the use of the VOCOMP system. In the department's Inglewood district office, a special task force was assembled—volunteer rehab counselors, a supervisor, and a statewide coordinator for VOCOMP—to receive advanced training and to make recommendations to the state about how to best implement VOCOMP for everyday use. A report

has now been submitted based on this task force's review and training sessions, with many practical suggestions for how to overcome operating difficulties.

Once computer terminals are on-line in the agency's district offices, counselors will be able to get back results in less than a minute on any client for whom they fill out a simple "fact sheet." This sheet contains data about the client's vocational history, education, job preferences, and functional limitations. The computer report that comes back from VOCOMP lists JOBS (with local labor market trends, salary, and requirements for background and training), and training programs in the client's area. The VOCOMP system can also be instructed by the counselor to prepare a special report on what jobs or training programs *would be available* if the client were to complete a high school degree or make some other change; and it can feed back information on how existing job skills could be *transferred* to other kinds of occupations.

The ongoing effort in the California state agency to implement VOCOMP has revealed many operating problems, some of which will be resolved by using recommendations from the Inglewood task force report. Others will require continuing efforts to improve the system by Innovative Software—particularly in the area of overcoming counselor resistance to the use of computers in their professional work. With more than a third of the nation's state rehabilitation agencies now exploring the use of VOCOMP by their counselors, the solutions to these problems may be very widely implemented within the next year.

For more information about VOCOMP, contact: Innovative Software, 19824 Ventura Boulevard,

Suite 102, Woodland Hills CA 91364 (213-884-5581).

Placement News

The agency Placement Unit has recently initiated several activities to assist the counseling staff in providing comprehensive job guidance and placement services to our clients.

Because of recent federal cutbacks in the Labor Department, testing services were severely curtailed. In order to fill this void, vocational rehabilitation and the Department of Employment Security developed a system to allow VR personnel to be trained in the administration and scoring of the General Aptitude Test Battery (GATB). The test battery measures nine aptitudes (intelligence, verbal, numerical, spatial aptitudes, form perception, clerical perception, motor coordination, finger dexterity, and manual dexterity) and is used in vocational counseling.

The response has been enthusiastic and over 50 agency clients were tested in March by these newly trained staff.

Other Placement Unit activities have expanded the job seeking skills workshops to involve the utilization of employers from the private sector to conduct the final practice interviews of clients to improve their self-confidence and jobseeking skills.

Specific career opportunities are being explored on a monthly basis with agency staff and client participation. Diane Franklin, Rhode Island Hospital Employment Manager, led off these seminars by discussing employment trends in the hospital field. Metropolitan Property and Liability Insurance Company sent two of their managers, Peter Velleco and James Marszalek, to acquaint the group with the potentials of accounting careers.

These meetings have allowed the counseling staff to have a greater awareness of private industry's changing needs.

Placement counselors from several agencies serving handicapped individuals in Rhode Island meet monthly to share information and discuss common concerns. Recent activities have included a joint presentation to a personnel association and discussion with a Social Security Administration staff member.

Rehabilitation In Rhode Island, R.I. Vocational Rehabilitation.

Information Booths Spread Word About Handicapped People

The Albany Area Office of the New York State Office of Vocational Rehabilitation reports that OVR informational booths were set up and managed by Albany Area Office counselors at community health fairs, held at local shopping centers, and professional conferences, New York State Public Health Association (NYSPHA). Public response at the community fairs showed that few people realize that OVR serves emotionally handicapped individuals, as well as physically handicapped and developmentally disabled people. Others thought that OVR "gets people jobs right away." Many were initially hesitant to approach the booth, but, after a few questions, requested referral information. A mechanically activated poster board, illustrating progress through evaluation and training, attracted a great many people—especially children.

Professionals, who were equally concerned with what OVR services are available, requested additional OVR

booths at area and national conferences. The exhibits generated interest and curiosity about OVR. The added plus was for the counselors, who enjoyed the chance to "go public."

—*The NYS OVR Sun.*

Communications Assessed

As cable television networks and satellite stations become more and more widespread, the use of telecommunications is gaining greater acceptance as a useful and affordable tool in business and government interactions. In line with this, an assessment was recently done at Rehab to determine whether use of this new technology would be feasible or valuable to the efficient operation of the department.

Telecommunications can take a number of forms, from computer terminals that connect with scattered locations, to meetings and conferences conducted via television, through dissemination of printed materials by facsimile printers. Rehab has used some of these methods on a limited scale. The purpose of the survey was to determine whether expansion of the department's telecommunications capacities would result in more efficient, less costly operations.

The survey, conducted by the Institute for the Future, consisted of a use questionnaire and interviews with key departmental staff. Questions centered on how internal communications are currently conducted (e.g., how much is written, by telephone or accomplished through meetings) and whether alternative methods might work as well or better. Outcome of the survey is not yet available, but it's probably safe to say that there will be some change in communications methods as this new technology becomes more widespread.

The telecommunications survey was part of Program Development Division's current initiative to explore the uses of new technology. The division is examining various innovative programs, such as cable TV training. . . to determine their applicability to Rehab's operations.

Questions on the telecommunications survey or any of Program Development's plans for new technology can be addressed to Deputy Director Ferd Shaw at (916) 322-6604 (ATSS 492-6604), voice or TDD.

Rehab Review, California Department of Rehabilitation.

San Jose Superstar

Job Club Coordinator Steve Conti and DORS Carol Pavan of the San Jose District are making a big hit with Silicon Valley employers with their presentation of the Windmills Awareness Training program. Dubbed the "turned on tandem" by D.A. Charles Meigs, the pair have presented the training package to over 480 employees of five major corporations with very positive results. To quote from a participant at the General Electric Company, ". . . we all came away from the workshops with a very positive feeling, and a better awareness of the limitations imposed by our mental attitudes—and a better understanding of the capabilities of persons with handicaps. Many myths and biases were dispelled."

This and other comments from satisfied participants attest to the effectiveness of the "Steve and Carol Show," as does the fact that the presentation is currently booked well into 1982.

Rehab Review, California Department of Rehabilitation.

Obfuscation is a term that defines the art of utilization of many big words on the preface that these words are

Language Used or Used Language?

We thought: "If we were asked to give one precept to social science writers that generally would improve their delivery, what would it be?" Immediately, the use of the passive voice jumped to consciousness, for, certainly, its use has become contagious . . . Yet. . . . How about the tag-along words that do just that, add words without adding to the meaning, as in classroom *area*, life *situation*, report *material*? They present, certainly, an avalanche situation! . . . And, yet . . . Well, there's the tendency toward the long phrase that is as easily given in a shorter form, as in, with the intention of (to); on a regular basis (regularly); or until the present time (until now) . . . But then there is the *ad nauseam* repetition of the theme, as in a paper that reminds us over and over again that we are reading about paraplegics.

All good points.

Certainly, elimination of any of them would improve style.

But not quite good enough. . . .

Well, what is? The most perfect example we could find was the "wolf in sheep's clothing syndrome," that is, the use of ineffective words that seem good, and look good, but aren't good: Many words are positive in connotation and, therefore, seldom need an adjective except to limit them. For example, an author who is writing about paraplegia may speak of the literature. Why would he want to add "available" literature? Or "relevant"

literature; or "existing" literature. For, certainly, the author would not have reviewed nonavailable, nonrelevant, and, especially, nonexistent literature!

Since early 1976 this column has given myriad examples of this (*trained* professional, *wide* array, *clearly* demonstrate, *firm* definition, *necessary* arrangement, etc.), but hardly a day passes that does not bring a new example. In diagnostic terms, this kind of usage is the symptom of a more discrete malady: sloppy thinking on the one hand and, on the other, blind acceptance of these pass-me-downs from others who display as much lack of thought as those who emulate them.

The remedy is simple: a positive word stands alone, *i.e.*, when one defines something, it already is "firm." If it is wrongly described, half described, or overly described then say that to *detract* from the positive word. Likewise, the word professional embodies *training*. These usages are a drain to the reader and symptomatic of thoughtlessness on the part of the writer. *When using a positive word, let it stand for itself.*

While the elimination of this bad habit would not make Hemingways of us all, it would go a long way toward more enjoyable communication.

Pastiche. Grab bags are great in junk sales; they have no place in precise writing.

Many columns ago, we noted that the word "utilization" had little (if any)

merit. Yet, we notice its continued use. It is an 11-letter word that can almost always be replaced by "use," "using," or "usage" (3, 5, and 5 letters respectively). Not only are these latter usages savings in space, but they are more euphonic and usually allow for better sentence construction.

In this world of alphabet soup: The SSA issued an OIP to be distributed to all POMS about the confusion caused by using MOE as an acronym for "month of entitlement." The confusion arose because MOE also means "month of election." The solution was as simple as ABC, making MOET the month of entitlement and MOEL the month of election, but poor MOE is no "mo." We suspect, however, that if you are a POMS, you would have known that SNAFU as bad SOPA and gotten rid of the bothersome fellow ASAP.

In an article about its premier gadfly of journalistic faux pas, the *Oakland Tribune* describes its bane of 53 years thusly:

"Herbert R. Korge, 71, in person, is like Herbert R. Korge, correspondent—cranky, crusty, cantankerous, opinionated, forward, frank and frustrated, earthy in speech, earthier in dress, a nit-picker of pomp, and a world viewer with no illusions about himself or others.

"He is honest—and likeable, if you can take criticism"

From Peter Matthiessen in *The Snow Leopard* (Viking Press):

"Now the air is struck by the shrill of a single cicada, brilliant, eerie, a sound as fierce as a sword blade shrieking on a lathe, yet subtle, bell-like, with a ring that causes the spider webs to shimmer in the sunlight."

In commenting on William Dean Howells, long considered the "Dean of American letters," Mark Twain said, "He seems to be always able to find that elusive and shifty grain of gold, the right word."

Utah Program Trains Mine Workers

Karl F. Kraync

The special Coal Mine Training Program of the Eastern Utah District of Rehabilitation Services was born of despair, of people who migrated to the area in hopes of obtaining employment in the local mining industry. The Eastern Utah District is located in one of the richest energy areas in the United States. Our area is experiencing a modest boom as the consequence of an expanding international coal market. This boom, in concert with the general decline of economic conditions in the rest of the United States, has caused a tremendous number of skilled and unskilled laborers to migrate to Carbon and Emery Counties. At the inception of the program, there were eight applicants for each mining position offered. In such an environment, hard-core rehabilitation clients were at an extreme disadvantage.

The genesis of the program was a late afternoon interview with a person who was contemplating suicide as a solution to his inability to support his family. Such despairing people were not rare.

The person in question, the graduate of a one-week mine orientation program, had just returned from a series of interviews with mine personnel officers all of whom had told him that they were hiring only experienced personnel. In desperation, equal to that of the client's, the College of Eastern

Utah was contacted to determine if a program could be developed that would provide sufficient training to make a hard-core, unemployed rehabilitation client appealing to the mining industry.

The outcome of the initial discus-

sions with the College of Eastern Utah was the creation of a special 17-week Coal Mine Training Program that was jointly sponsored by the College of Eastern Utah, State Division of Vocational Education, Division of Rehabilitation Services and Industry. The pro-



First graduating class. Back row, l. to r., Roy Sink, instructor; James McCall; Miguel Soto; William Skillingstad; Frank "Kotter" Burge, instructor; Darrell Richards; Richard Woodland, instructor; and Karl Kraync, district supervisor. Front row, Terry Hurtado, Kathy Hilliard, Gilbert Tucson, and Maryanne Young.



Top, left. Gilbert Tucson demonstrates welds to instructor Roy Sink. Left, middle. Instructor Sink demonstrates operation of welding apparatus. Left, bottom. Terry Hurtado assembles major part of Joy Buggy. Above. Darrell Richards practices with drill press—students became familiar with most equipment found in industrial shops.



gram curriculum included intensive training in mine orientation, mine rescue, mine technology, and emergency medical technician training.

Having the program sponsored, the next most important task was selection of a program staff. The Rehabilitation District committed three rehabilitation counselors, all of whom had clients who would be participating in the program. The College of Eastern Utah committed two program instructors and one person who would serve as the student advocate throughout the course of the program and who later affectionately became known to his students as "Kotter." The students, in return, were nicknamed the "Sweat Hogs."

With all program elements in place, counselors in the Price office were requested to select some of their most hard-core, unemployed clients for placement in the program. From a potential field of 120 people, 13 of the most physically capable, economically disadvantaged, emotionally handicapped persons were selected for enrollment. Client backgrounds included people with extensive criminal records, poor or nonexistent work histories, long term dependence upon the welfare system, and emotional disabilities. Program enrollees shared the common characteristics of distrust, hostility, hopelessness, and anger. Of the 13 original participants, one was placed in the mining industry midway through terminated from the program for behavioral problems is currently employed by a mining company. Only two clients who were terminated from the program are considered to be failures. Nine individuals, who have completed the program in its entirety, are currently interviewing with local mining companies, and it is anticipated that all nine will be placed in employment before the program is completed.

Training

For seventeen weeks students in the Special Mine Training Program were engaged in the most demanding training offered at CEU. For six of the seventeen weeks, students attended class seven days a week for 12 hours a day. The training provided could be defined in three categories: coal mine safety, mine maintenance, and social employment skills.

The mine safety component included mine orientation, emergency medical technician training, and basic mine rescue. Mine orientation students were taught basic mine safety, general procedures relating to the production of coal, and the rights of a miner in relation to safety. All students completed EMT Training and four are now certified EMT's. This certification will allow graduates to serve as crew members on mine emergency equipment. During the basic mine rescue, students learned the use and function of the various breathing apparatus used in rescue operations. They were also instructed in various techniques of operating rescue equipment in a gaseous environment.

The mine maintenance component of the program accounted for most of the training effort. Students learned the basics of hydraulics, welding, mine electricity, diesel mechanics, and general mechanics. The theory learned in the classroom was translated into hands on experience in the shop. Students disassembled, serviced, reassembled and made operative major components of mining equipment.

Social skills were taught on a formal and informal basis throughout the program. Every Friday the client advocate met formally with the class to conduct "job-seeking, job-survival skills" seminars, and deal with the problems. Rehabilitation and college staff used classroom problems such as

late incentive pay as mechanism to teach students the difference between appropriate and inappropriate behavior.

The metamorphosis achieved by those who have completed the program is truly dramatic. Earrings, bandannas, and side knives have vanished. Personal hygiene and attention to appearance have improved remarkably, but, most important, is the change in attitude by those who have completed the program. The nine program participants have learned to depend on each other, to look after each other, and, most importantly, to care for each other.

Having tasted success, all participants now desire further success. Many anticipate returning to school after a period of employment. The success of the program participants has been a hard fought fight. Instructors, rehabilitation staff, and most significantly the client advocate have worked after hours and on weekends dealing with the training and personal problems of the clients.

Crises have included everything from a weekend drunk to dealing with a panic stricken husband waiting for his wife in the obstetrics waiting room of the local hospital.

A number of factors are considered significant in the success of this program: the technical skills, patience, and devotion of the College of Eastern Utah staff, the client advocate who interceded so often for the client, and the untiring efforts of the rehabilitation counselor who served as friend, advocate, and disciplinarian to the client. Nonetheless, none of these would have mattered without the honest desire of the program participants to succeed.

Dr. Kraync is the District Supervisor, Eastern Utah District, Division of Rehabilitation Services.

Preparing Manuscripts For Publication

Ansa Ojanlatva

The year of 1981, International Year of Disabled Persons (IYDP) was devoted to community participation by the disabled people. It was also the time for able-bodied community members to facilitate better interaction with disabled people. Each of us has a different set of values, different sets of skills and abilities. Therefore, it could be expected that each of us has preferences as far as our involvement with IYDP.

This author values activities which extend beyond a particular time period, activities which have a lasting value, and activities which are educational. As a personal endeavor, it seemed appropriate that time spent on surveying needed information and writing about it would help others with similar needs and knowledge. Therefore, a decision was made to find specific tools for planning to advance health and wellness of disabled people through writing and to survey disability related publications regarding manuscript preparation.

From a writer's standpoint, the project had two objectives. First, editors of selected journals seemed to continuously note that many writers were turned down for having selected the wrong journal for the manuscript or made errors in the first submission, among other things. By having certain questions answered prior to submitting, unnecessary steps may thus be avoided.

Second, by having information on specific steps in manuscript prepara-

tion, a beginning author may be motivated for additional and faster writing endeavors.

A questionnaire with a cover letter and with a stamped, self-addressed envelope was mailed to editors of 40 national publications pertaining to disability.

Some mailings were returned undeliverable due to moving or going out of business. Others had changed their status to that of a newsletter, or they turned out to be newsletters from the beginning.

The results of 17 returned questionnaires were compiled into this article. They include journals, magazines, and newspapers. The one common factor is that each accepts health education related manuscripts providing that articles fit the publication policies.

The requested information on the form included the name of journal, name of editor, address and telephone number, as well as 15 specific questions categorized in the following ways.

The background information of the journal included circulation of the journal, kinds of audience it reaches, and how many times it is published each year.

Questions related to manuscript preparation requested the number of manuscripts submitted annually, how many are published, what kinds of articles are acceptable, and what the specific criteria of writing and language usage might be.

Questions helping in the decision making regarding a specific journal

the author might want to choose included the length of the review process, person receiving the manuscript, requirements about the potential author, and whether the journal had an editorial board.

Future trends and happenings were investigated with four questions: any possible recommendations for expanding the present writing market for health-oriented/health educational writers, any new departments being planned and considered, complimentary copies available to contributors, and whether health education manuscripts are acceptable.

Guidelines For Contributing Authors

Two kinds of journals, magazines, and newspapers can be found in this article. In addition to the fact that only those publications which accept manuscripts on health education issues are listed, publications with an editorial board and those without one are described separately. This will assist those writers who prefer technical articles from those solely conversational.

The project was reviewed by the University of Houston Committee for the Protection of Human Subjects, and the writing project can, therefore, limit itself only to the information specified by the editors. Some have additional guidelines and they may be requested from the editorial offices.

Publications With An Editorial Board

AMERICAN ANNALS OF THE DEAF. Editor: Dr. McCay Vernon.

Address: 814 Thayer Avenue, Silver Spring, MD 20910. Telephone Number: (301) 585-4363

American Annals of the Deaf is published bimonthly and additional bonus issues come out periodically. The circulation is approximately 5,000 to people in the field of deaf education and other related fields. The articles cover research, philosophy, and topical areas such as teaching.

Approximately 100 manuscripts are submitted yearly to the editor and about 30 are accepted each year. Anyone may send a manuscript for consideration. The review period is about 8 weeks.

The contributing authors should contact the editor for guidelines with specific criteria for language, style, etc.

A complimentary copy of the published article will be sent to the author.

AMERICAN REHABILITATION. Editor: Ron Bourgea. Address: Rm. 3525 MES, 330 C Street, S.W., Washington, DC 20202. Telephone Number: (202) 472-5296.

American Rehabilitation is the official bimonthly publication of the Rehabilitation Services Administration, with a circulation of 8,000-9,000 to an audience of rehabilitation professionals. Articles published contain research, philosophy, and topics and programs related to rehabilitation.

The editor receives about 50 manuscripts, some of which are solicited. An average of 30 of them are published annually. Anyone can be a potential author. Manuscripts are sent to selected reviewers, and a decision about publication is made in 1-2 months.

The publication uses simple, non-journal, nontechnical language. Papers should be typed, double-spaced, about 12 pages in length, and hold references to a minimum. Guidelines for manuscripts are available from the editor.

Six complimentary copies of the

magazine are provided after publication.

ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION. Managing editor: Marvin A. Schrider. Address: Suite 922, 30 N. Michigan Avenue, Chicago, IL 60602. Telephone Number: (312) 236-9543.

The Archives of Physical Medicine and Rehabilitation is the official journal of the American Congress of Rehabilitation and the American Academy of Physical Medicine and Rehabilitation, published monthly. It accepts original papers on research, philosophy, and topical areas, such as physical medicine, rehabilitation, and psycho-social experiences. The audience of 7,000 are professionals in rehabilitation medicine.

Approximately 275 manuscripts are submitted for publication every year, 150 of them accepted and published. The editorial board receives manuscripts and makes a decision within 90 days. Three copies of the manuscript (the original and two copies) are required at the time of submission. A cover letter indicating the corresponding author, address, and phone number should be included. This letter should state that they assign the copyrights to that manuscript to the journal. The journal will not review manuscripts which have been submitted elsewhere at the same time. Nor will an oral presentation be acceptable in the same form, but it will have to be revised before the review.

The articles published will appear in one of the following contribution categories: articles (not to exceed 6500 words), clinical notes, prosthetics, orthotics and devices, commentary, editorial, letter to the editor, forum reports (often prepared by a moderator of a forum), and rehabilitation focus (a clinical or medical condition or treatment rather than a diagnosis).

The components of the manuscript are title, by-lines and supplementary information, abstract, headings, acknowledgements, footnotes, possible addendum, reprint address, references, and data.

The journal has specific rules and regulations regarding composition and style, and, therefore, authors should obtain specific instructions for authors from the managing editor.

The journal will provide a complimentary copy, but reprints—bought.

EDUCATION OF THE VISUALLY HANDICAPPED. Editor: Mary Singer. Address: Heldref Publications, 4000 Albermarle Street, N.W., Washington, DC 20016. (202) 362-6445.

Education of the Visually Handicapped is a quarterly publication by Helen Dwight Reid Educational Foundation, and distributed to educators, parents, and others interested in visually handicapped children, youth, and young adults. Articles cover research, philosophy (including controversial areas), and topical areas, such as useful practices in administration, teaching, curriculum development, counseling, educational technology, programs at all levels, litigation, legislation, regulation, and international educational experiences.

Each year the editorial board reviews approximately 50 manuscripts, 20 of which are accepted for publication after 2-3 months of review. Anyone is invited to send proposed articles to the editor. These should be 2,500 words or less in length and double-spaced, they should follow American Psychological Association format and be followed by a cover letter.

Each contributor is provided with two complimentary copies of the journal at the time of publication.

HEARING REHABILITATION QUARTERLY. Editor: (Ruth R.

Green, Administrator). Address: New York League for the Hard of Hearing, 71 West 23 Street, New York, NY 10010. Telephone Number: (212) 741-7650.

The journal, published quarterly, has an audience of about 2,200 of hearing-impaired persons and professionals in the field. The articles are topical areas related to hearing loss. Of the 20-25 proposed papers, 20 are accepted each year. The review by the board will take about 2-3 months.

The manuscripts with a message of interest to the hearing-impaired consumers and professionals are invited from anyone, and they should be sent to Ruth R. Green, Administrator.

A complimentary copy will be sent to the author.

JOURNAL OF REHABILITATION. Editor: Dick Dietl. Address: 633 So. Washington Street, Alexandria, VA 22314. Telephone Number: (703) 836-0850.

Journal of Rehabilitation is published quarterly and circulated to 17,000 rehabilitation professionals in different institutions. Articles include research, philosophy as well as topical areas and issues of human interest.

Of the 100 manuscripts submitted to Jane Sink, Editor of Professional Articles, 45 are published annually. Anyone may send manuscripts for consideration, but National Rehabilitation Association members receive priority. The review period is 60-90 days.

The manuscripts may be professional or they may describe issues of human interest. Any further guidelines should be requested from the editor. The editor's comment on recommendations for expanding the present writing market for health-oriented/health educational writers included an encouragement for beginning authors:

10 "Do not be afraid to be rejected. Submit

your efforts and keep submitting."

A contributor will receive two complimentary copies and tear sheets of the article.

JOURNAL OF SPEECH AND HEARING RESEARCH. Editor: Frederick T. Spahr, Ph.D. Address: 10801 Rockville Pike, Rockville, MD 20853. Telephone Number: (301) 897-5700.

Journal of American Speech and Hearing Research is the journal of American Speech and Hearing Association, published monthly and distributed to an audience of about 45,000 members. The articles cover research and philosophy, written in informational but conversational style.

Anyone is invited to send manuscripts to the Articles Editor. About a third of 15 submitted papers are published annually. The review period is 3 months. The editor is inviting ideas for new departments and accepts health education manuscripts providing they are related to communication and communication disorders or are applicable to health education professionals.

A complimentary copy is sent to the contributor.

JOURNAL OF REHABILITATION OF THE DEAF. Editor: Glenn T. Lloyd, Ed.D. Address: Rt. 5, Box 535A, Morganton, NC 28655, or Box D-46, North Carolina School for the Deaf, Morganton, NC 28655. Telephone Number: (704) 433-2967.

The journal is a publication for the professionals in the field of deafness, numbering 1,500 at the present time. Four times a year research applications to the field, implications of completed research, philosophical articles and appropriate topical illustrations are published. The journal discourages manuscripts with pure/basic research.

Manuscripts are invited from anyone interested in the above-mentioned

areas. Of the 30-40 papers submitted each year, approximately 18-24 are eventually published. The letter should be addressed to the editor. The review period is 1-3 months.

The journal uses American Psychological Association format. The editor stresses *understandable* composition: clear language with appropriate syntax and grammar, and with appropriate construction.

The editor is receptive to new ideas and new departments for the journal.

A complimentary copy should be requested by the contributor from ADARA, 814 Thayer Avenue, Silver Spring, MD 20910.

JOURNAL OF VISUAL IMPAIRMENT AND BLINDNESS. Editor: Mary Ellen Mulholland, Editor-in-Chief. Address: 15-W. 16th Street, New York, NY 10011. Telephone Number: (212) 620-2150.

Journal of Visual Impairment and Blindness reaches an audience of 5,000 researchers and practitioners professionally concerned with visual impairment (educators, psychologists, technologists, rehabilitation personnel, sociologists, people in arts and recreation) ten times each year. The main areas of interest are research and topical areas related to visual impairment and living.

Manuscripts are invited from the readers of the journal. Of the 300-400 submitted papers, 75-100 are published yearly. The cover letters should be addressed to the editor-in-chief. It takes about 3 months to have a paper reviewed by the editorial board.

Manuscripts should be free of jargon. The style can vary from technical to conversational depending upon the content. The author may request "Guidelines for Contributors" from the editorial office.

The editor-in-chief is receptive to new suggestions regarding new depart-

ments for the journal.

The contributor will be provided with a complimentary copy.

REHABILITATION LITERATURE. Editor: Stephen J. Regnier. Address: 2023 West Ogden Avenue, Chicago, IL 60612. Telephone Number: (312) 243-8400.

As a bi-monthly journal, *Rehabilitation Literature* is mailed to 3,500 professionals and students in rehabilitation. The articles range from research and philosophy to almost any rehabilitation related topical area.

Forty articles, written by any interested person are published from among the 150 submitted manuscripts each year. The proposed papers should be mailed to the editor, and review takes about 2-4 weeks.

A guideline for contributors may be requested from the editor.

Regarding recommendations of expansion of the present writing market for health-oriented/health educational writers, the editor encourages the authors to make articles more general for broader audience's reach.

A contributor will receive a complimentary copy.

REHABILITATION PSYCHOLOGY. Editor: Mary A. Jansen, Ph.D. Address: American Psychological Association, 1200 Seventeenth Street, N.W., Washington, DC 20036. Telephone Number: (202) 833-7578.

Rehabilitation Psychology is a quarterly published journal by the American Psychological Association intended for psychologists and other health professionals interested in rehabilitation. Its circulation is 2,000.

Manuscripts on research, philosophy, policy making, and topical areas related to clinical practice are accepted from anyone interested in rehabilitation psychology. The letter should be directed to the editor. The review period is about 2 months.

The proposed manuscripts should be about 12 pages long, written in American Psychological Association style, and be on research in the area of behavioral interventions designed to reduce the incidence of health problems.

A complimentary copy will be provided once the article is published.

THE VOLTA REVIEW. Editor: Richard R. Kreschmer, Jr., Ed.D. Address: The Volta Review, Alexander Graham Bell Association for the Deaf, 3417 Volta Plaza, N.W., Washington, D.C. 20007. Telephone Number: (202) 337-5220.

The Volta Review is a research journal dedicated to publishing articles on speech, language, and hearing impairment. Seven times a year it is mailed to an audience of 7,100, but the potential readership is estimated to be larger than 50,000 consisting of special education teachers, audiologists, speech-language pathologists, other speech, hearing and rehabilitation professionals, hearing-impaired adults and parents of hearing-impaired children.

Anyone interested in contributing to the journal is invited to send manuscripts to the managing editor. The review by the review board will take about 3-4 months.

Articles which are not overly technical are preferred. They should be no more than 15 pages in length, and follow American Psychological Association style manual.

A complimentary copy is provided to contributing authors.

Publications Without An Editorial Board

ACCENT ON LIVING. Editor: Raymond C. Cheever. Address: P.O. Box 700, Bloomington, IL 61701. Telephone Number: (309) 378-2961.

ACCENT on Living Magazine is published four times a year and deliv-

ered to an audience of 18,000 consisting of all kinds of disabilities, parents of handicapped children as well as specialists and counselors in the field of rehabilitation. Informal articles on the following kinds of topics are published: new devices and medical techniques, discussion articles regarding normal living situations, how-to articles concerning everyday living, up-to-date news articles about disabled people, disabled personalities and persons in public life, interviews, and other miscellaneous areas of interest, including architectural barriers, vacations, accessible places to go, sports, organizations, humorous incidents, self-improvement, and sexual and personal adjustment.

Of the several hundred manuscripts submitted, 2-3 major articles (issues) are chosen yearly. Further, several others are abbreviated or published as photo stories. Anyone can submit manuscripts which should be mailed to Betty Garee, Assistant Editor.

Short (250 to 1000 words), tightly written, typed, double-spaced articles are acceptable. The magazine will pay for both articles and photos as well as for cartoons. The rates vary from \$20-200 depending on quality. The author may purchase a copy for \$1.50.

ACHIEVEMENT: NATIONAL VOICE OF THE DISABLED. Editor: C.T. Lamos. Address: 925 N.E. 122nd Street, North Miami, FL 33161. Telephone Number: (305) 895-0153.

This is a newspaper published 8-12 times a year. The audience of 8,000 consists of disabled people and professionals in schools and community agencies, governmental agencies included.

Most of the several hundred manuscripts submitted to the editor for publication are accepted yearly. The newspaper publishes both philosophical and (Continued on Cover III.)

Information About Rehabilitation Information

Eleanor L. Biscoe and Mark X. Odum

The value of information is relative. It is priceless if timely and pertinent to a person, family, or organization in need of specific knowledge or know-how. Information, on the other hand, can be useless if inaccurate, irrelevant, or inaccessible.

Note the emphasis on the work "needed." Information is useful and considered valuable only when perceived to be needed. This is why rehabilitation information is of little interest to those outside rehabilitation circles and so valuable to rehabilitation professionals and their clients, once they obtain and use it. Rehabilitation professionals, policy makers, educators, researchers, and allied medical personnel need information on a continuing basis to serve client populations. Not just any information, but specific information tailored to immediate needs. Seekers also must know where and how to request information.

Obtaining information is difficult for many people, both on a professional and a personal basis. That is why NARIC—The National Rehabilitation Information Center—promotes its resources and services.

Effective promotion and education enables people to learn about the center, and provide an opportunity for people to obtain information that may not have been available. Awareness of the center's services and products is the key to NARIC's effective use.

Awareness means being conscious and cognizant of something. In the

case of rehabilitation information sources, "information source awareness" means knowing who to consult for either specific data or where to obtain an organizational referral. The center attempts to heighten potential user awareness about data through workshop presentations and demonstrations, journal articles, personal contact, and booth management at conferences. NARIC's presence through effective presentations about rehabilitation information yields better informed professionals who are willing to ask for information that they need to carry out their responsibilities.

Rehabilitation professionals who do not feel comfortable about asking for information don't. Those aware of NARIC and its strengths do. This is true for most people in relation to information organizations. Thus, NARIC channels energy into helping rehabilitation personnel and persons with interests in the disability field to learn how to identify and use information.

NARIC is a research utilization project funded by the National Institute of Handicapped Research (NIHR) and formerly by the Rehabilitation Services Administration (RSA). The project has grown from a one room office in 1977, to a fully developed information center with its own building and 15 NARIC "team" members who answer over 1,200 inquiries per month in 1982. In addition, the NARIC team develops two rehabilitation databases.

The project has three main components. The first, REHABDATA, is a computerized file of bibliographic information citing documents and non-print materials in the NARIC research collection. The database captures information on rehabilitation research reports, commercial publications, and journals. There are two manual files of resource and factual information supplementing REHABDATA's information. Staff members provide information services for national and international requestors.

The center's second information system, ABLEDATA, is a computerized file of commercial rehabilitation product information and a network of information brokers. The brokers are located throughout the country and disseminate national and local information.

The third part, Communications and Publications, includes all the outreach activities and services performed by NARIC's entire staff to promote the center's collection and services and to further the use of rehabilitation research.

Making NARIC "accessible" is the cornerstone of the project's research utilization plan. How NARIC makes research results useable and accessible is further discussed in this article.

How NARIC Makes Itself Accessible

Anyone may call NARIC at (202) 635-5822, between 9:00 am and 5:00 pm, Monday through Friday, or leave

a message on the telephone answering device after hours or on weekends. People may use the wheelchair-accessible library in the center, located at 4407 Eight St., N.E., Washington, D.C., 20017 on the campus of The Catholic University of America, during the same hours. Transportation details will be given if patrons telephone before coming, or a map will be mailed.

Requests for information can be initiated by telephone, mail, or in person. Every request is answered by an information specialist. When answering requests, these specialists have the technology and know-how to search REHABDATA, ABLEDATA, or other commercial databases, the center's manual files, or refer the request to other sources of information. No question received at NARIC goes without a response.

REHABDATA

If one is looking for current disability information, especially if it's research-oriented, chances are it can be found in REHABDATA. This unique research collection contains information on more than 7,000 documents pertaining to all phases of rehabilitation.

Information in the REHABDATA file is basically divided into three categories. They include research reports (dating from the 1950's to the present) published by NIHR and RSA-sponsored projects, commercial publications and documents from other agencies and organizations, and abstracts of journal articles selected from 25 major professional publications.

The REHABDATA file contains citations consisting of 10 data fields and an abstract. An abstract is a brief description of the document's contents. Searches are performed by matching terms from the citation with the information desired by the requestor.

This "free-text" method of searching allows information specialists to generate custom bibliographies of the NARIC collection. The center keeps copies of approximately 75 popular subject bibliographies updated monthly on file. Examples include directories, mental retardation, physical therapy, and placement.

The REHABDATA database is available to the public nationally and internationally. Information in the file can be accessed by anyone with a computer terminal, subscription to the Bibliographic Retrieval Service (BRS), and a telephone. BRS is a database vendor in Latham, N.Y. which stores the REHABDATA and ABLEDATA files. The Microfilming Corporation of America, a subsidiary of the New York Times, films and markets a microfiche collection based on the REHABDATA file.

To help answer general information requests, the center has developed two manual files in addition to REHABDATA. Data specifically not entered into the REHABDATA file is arranged in a "vertical file." This data holds information about organizations and rehabilitation subjects. Ready-reference information, such as contact people, statistics, and telephone numbers can be quickly accessed from the "fact file." Both files contain local, national, and international information.

Frequently, information seekers require data found in databases other than in NARIC's collection. Information specialists have the ability to search numerous commercial, online databases. Users of this service are charged only the "online" fee that is charged by the database owner. Examples of such databases are ERIC, MEDLINE, and PSYCH-ABSTRACTS.

Referral is a daily tool employed by information professionals worldwide

to supplement collections and services. NARIC's specialists participate in informal working relationships with other organizations that provide information about rehabilitation. These organizations and NARIC maintain an "information and referral" network to expedite information request handling. No one source of information is sufficient to meet all rehabilitation-related information requests. Therefore, the nurturing and continuation of organizational relationships to improve the overall provision of information is a high NARIC priority. NARIC has initiated a selected number of "Memoranda of Agreement" to formalize some relationships.

Document delivery is a major function which promotes research use. For every NARIC bibliographic citation, there is at least one copy of the document in the NARIC library. The center will photoduplicate any noncopyrighted document for a cost of .10 per page.

ABLEDATA

The center's newest database, ABLEDATA, helps to meet the increasing demand for information about commercial rehabilitation products and devices. The ABLEDATA database is a computerized file of product data entries describing equipment and aids. There are 10 data fields for each entry. The fields include terms such as generic and brand name, manufacturer, distributor, cost/year, and description.

The file consists of more than 5,000 product entries. Direct access is available through a network of information brokers trained by NARIC to search the database. The ABLEDATA system manager, headquartered at NARIC, conducts specific information searches and coordinates the information broker training program. Agencies and organizations should contact

NARIC for information concerning how to be part of the ABLEDATA system or how to conduct an information broker function. There is also a supplementary manual information file of over 1,000 commercial catalogs of equipment and devices.

Funding for start-up of the ABLEDATA system was provided through contracts issued by the California State Department of Rehabilitation to NARIC, to coordinate with the initial work carried out through the University of Virginia's Rehabilitation Engineering Department. ABLEDATA efforts were centralized under NARIC in October 1981. Requests for product information or information about the broker training workshops can be answered by calling the center's ABLEDATA telephone (202) 635-6090.

Publications

In 1979, NARIC began publication of an eight-page newsletter, *The Pathfinder, Your Guide to Resources and Technology in Rehabilitation*, to inform the public of NARIC's programmatic developments, including the latest research information and technology in the field. The newsletter was initiated to reach the rehabilitation community on a regular, dependable basis. Yearly subscriptions are \$7 for inkprint and \$12 for braille. Complimentary copies are widely circulated at national and international conferences, conventions, and meetings. Single copies are included as part of the center's general information package on request.

A *Thesaurus of NARIC Descriptors* was published to help organize and control the vocabulary in the REHABDATA database. The thesaurus is the chief tool used in accessing online data, and was developed to systematize the terms and definitions used at the center. Due to predictable changes in the vocabulary, the thesau-

rus was designed to accommodate continuous updates. Many individuals, organizations, and libraries find this tool useful in developing rehabilitation files and collections.

In 1978, a simple list with bibliographic information was published to regulate the center's periodical holdings. Later the list was refined and reprinted as an *Annotated List of Periodicals* containing a brief description of each periodical. The list cites title, subject, and publisher information on more than 220 magazines relevant to the field of rehabilitation. This is another practical tool which assists individuals and agencies select and use journals in the rehabilitation field.

In 1982, the center developed and produced a *Subject Catalog*, which is a printed list of documents of the REHABDATA file, broken down by subject. Because of file size, only 50 of the most requested topics will be in the catalog. This document has full bibliographic information, plus a list of all subjects found in the REHABDATA file.

Due to the increasing volume of NARIC information requests, the center began publishing a *Fact Sheet Series* to answer questions on constantly requested topics. These fact sheets are written by information specialists and address current subject areas. Each has a bibliography of NARIC documents pertaining to the topic and aid disseminating the center's information. The series provides concise information on rehabilitation subjects.

The center puts a high priority on producing publications to make all aspects of the NARIC project easily accessible. These publications have been developed to publicize the collection and services: disseminate NARIC information nationally and internationally; provide easy access to information in the system; inform the rehabilitation public of programmatic

developments; and promote and further the use of research results.

Outreach Strategies

Outreach activities help promote NARIC's services and collection to the rehabilitation field. The center achieves a greater user base and increases awareness to new users through promotional activities. Frequently presentations are given to groups of professionals, usually rehabilitation practitioners and information providers at conferences, conventions, and specialized workshops and meetings. A customized packet of NARIC material is distributed. The packets are targeted to get the maximum "ripple effect" by urging that information be passed on.

At the larger conferences and conventions, booth displays gain a greater visibility to general attendees. Specialized materials are prominently displayed for review. Whenever possible, demonstrations of the REHABDATA and ABLEDATA files via a portable computer terminal are held.

In four and one-half years, NARIC has grown from an idea to what is now a well organized, cohesive operation currently responding to almost 15,000 inquiries per year. The project's collections, services, and publications have all grown as more research and information is being generated or captured. The center's work is important to the entire rehabilitation community—the counselors, administrators, researchers, educators, engineers, but most important to the disabled themselves. Beyond this community, however, is the larger public, with its growing awareness and commitment to the needs and rights of the disabled in becoming part of the American mainstream.

Mrs. Briscoe is the Center Director and Mr. Odum is the Editor of NARIC publication, *Pathfinder*

PUBLICATIONS & FILMS

Women and Rehabilitation of Disabled Persons. Leonard G. Perlman, Ed.D., and Kathaleen C. Arneson, editors. Switzer Memorial Fund, NRA, 633 S. Washington Street, Alexandria, Virginia 22314. \$10.

"Women and Rehabilitation of Disabled Persons" is the monograph of the proceedings of the Sixth Switzer Memorial Seminars. It contains five chapters written specifically for the monograph and focuses on disabled women in the following topical areas: employment, access to benefits and services, special populations and international programs for disabled women. In addition, there is one chapter on the leadership role of women in rehabilitation.

The monograph contains implications and recommendations for action for service delivery, program and policy development, research, training, and legislation.

State Salary Survey. August 1, 1980. Office of Intergovernmental Personnel Programs, Office of Personnel Management, P.O. Box 14184, Washington, D.C. 20044.

The following is quoted from the report's introduction:

"The *State Salary Survey*, published annually since 1973, provides data which may assist state governments in 'providing equitable and adequate compensation,' one of the six merit principles set forth in the Intergovernmental Personnel Act.

"This year the survey shows general salary increases in 48 states, five more states than in 1979. One state showed no changes in any classes because the state legislature only meets every 2 years. Two states showed increases for some classes but not for

most classes. One state showed increases in all of its maximum salaries but only two-thirds of its minimum salaries.

"The survey covers 31 occupational categories, with 104 titles generally described as administrative, professional, or technical. They include positions which are commonly used by state governments, employ relatively large numbers, represent a new program or one of special significance in state administration, or have key importance as a basis for adjusting state pay plans.

"For most occupations, three benchmark levels are described: beginning, experienced or supervisory, and administrative or executive. The descriptions follow a standard format, *i.e.*, summary definition, degree of supervision and responsibility, examples of duties, and usual qualification requirements. Standardized language for experience requirements has the following interpretation: 'some' experience—less than 2 years; 'considerable' experience—2 to 5 years; 'extensive' experience—over 5 years."

Tables for vocational rehabilitation counselor and vocational rehabilitation director are included.

Advancing Your Citizenship: An Advocacy Manual For Persons With Disabilities. A. Crosson, P. Browning, and R. Krambs. Rehabilitation Research and Training Center in Mental Retardation, Clinical Services Building, University of Oregon, Eugene, Oregon 97403. 1979. \$3.

This manual is intended to assist disabled people in exercising their rights of citizenship. Presented in a question and answer format, it is ex-

pressly written for handicapped people, their parents, and their advocates.

The first section overviews three major pieces of federal legislation: The Education for All Handicapped Children Act (Public Law 94-142), the Rehabilitation Act of 1973 (Public Law 93-112, as amended), and the Developmentally Disabled Assistance and Bill of Rights Act (Public Law 94-103, as amended).

The second section discusses four specific consumer protection mechanisms: individualized program planning, nondiscrimination, least restrictive alternative, and procedural safeguards in education.

The third section consists of case studies which illustrate the interpretation of the legislation and the application of the consumer protection mechanisms.

Employing The Disabled: What Are Self-Help Groups And What Assistance Can They Offer the Employer? Rami Rabby. 136 East 55th Street, Suite 8E, New York, N.Y. 10022. 23 pages. \$5.50.

Drawing on his experience as director of affirmative action programs for the handicapped at Citibank, and on his practice as a consultant on employment of the disabled and other aspects of institutional integration of the handicapped, Rabby develops a working definition of disabled advocacy groups and distinguishes between their role, on the one hand, and the role of other types of organizations and agencies in the field of disability, on the other. He then offers examples and illustrations of how employers and disabled self-help groups can collaborate in outreach and recruitment, awareness training for supervisors and coworkers, removal of architectural barriers, and modification of discriminatory personnel practices.

Notes on the margin...

DISABLED PERFORMERS

The Performing Arts Theatre of the Handicapped (PATH) holds monthly interviews and auditions for handicapped performers and artists (by appointment) via THETA CABLE, the newest way for television producers and casting directors to meet talent.

PATH helps talented handicapped people seeking careers in the theatre, motion pictures, television, radio, and other media through training and guidance. Future plans include programs for writers, directors, lighting technicians, set designers, and other "behind the scenes" personnel. For more information, contact PATH, 5410 Wilshire Blvd., Suite 904, Los Angeles, CA 90036. (213) 938-7768.
--Human Development News.

BLIND ARTISTS

The National Exhibits by Blind Artists, Inc. (NEBA) of Philadelphia will open its Fifth Art Exhibition in October 1982 at the Philadelphia Art Alliance. The exhibit will also travel in 1983 to the Wadsworth Athenaeum in Hartford and the Brooklyn Museum.

All legally blind artists are eligible to enter, and all entries must be original works of art. Art works for consideration include painting, printmaking, sculpture, photography, drawing, furniture, needlework, fabric design, weaving, jewelry, metal smithing, wood carving, and other categories usually considered original fine arts or crafts. For more information or official application forms, contact NEBA, 32 Chestnut Road, Paoli, PA 19301. Applications are available in braille, if requested.

DEAFNESS SERVICE

In its year of operation, the National Crisis Center for the Deaf at the University of Virginia in Charlottesville has processed 1,200 calls from people living in 40 states. The service provided services in a wide range of areas, from personal counseling, medical information, burglary intervention, to arranging for an interpreter for a meeting between a deaf person and a policeman. The service operates 24-hours a day and is toll free: 1-800-446-9876 and in Virginia 1-800-552-3723. Hearing people may call 804-924-1847.

HEARING IN CONGRESS

The Visitors' Gallery in the United States House of Representatives and the United States Senate are now equipped with an audio loop, giving hard of hearing visitors the opportunity to listen to their elected representatives. Installation of the audio loop was accomplished by cutting into the audio system that was already in place.

ITALIAN CENTER OPENED

In Italy a new institution called S.I.V.A., the Servizio Informazioni e Valutazione Ausili, has been established to work with information and evaluation of technical aids.

Currently, the S.I.V.A. is building a computer program in order to simplify the information about technical aids. The system will include aids specially intended for disabled people as well as other products on the market which might be used as technical aids.

Further information is available from the S.I.V.A., Via Gozzadini 7, 20148 Milan, Italy.

ASPIRIN & CATARACTS

An article in the March-April 1982 edition of The Star (N.H.D. Center, Carville, LA 70721) by K. Prabhakaran, Ph.D., explores the relationships of aspirin and vitamin C in delaying senile cataracts.

Independent Living And Learning Disabled Adults

Dale Brown

A few months after graduating from high school, Chris Falbo moved into Chapel Haven, a community which would help him learn independent living skills. He is a tall, handsome man with dark brown hair and warm hazel eyes. He doesn't look disabled. His hands look strong and capable.

But he needs special training to efficiently use his hands. He is learning disabled. He has difficulty taking information in through his senses and organizing it. Like static on the radio or a bad TV picture, the information gets garbled as it travels from his eyes, ears, or skin to his brain. And when his brain tells his body what to do, the correct message might not reach his hands.

Because of this faulty communication system within himself, he has difficulty learning the ordinary tasks of daily life. He can learn, but it takes more time and effort. He must be taught systematically.

Learning disabled people are not alone in needing this extra help. People with mental retardation and emotional disturbance also need structured approaches that help them begin their adult life. Many group homes have been developed for them. Some overlap exists between programs for moderately mentally retarded and learning disabled people, since many of the same techniques serve both populations.

Learning disabled people are particularly underserved. Only four residential programs in the United States

say that they have mostly learning disabled people.

All four programs teach the residents "activities of daily living" such as cooking, budgeting, cleaning, and shopping. They live in furnished apartments which contain their own living room, kitchen, bathroom, and bedrooms. They live with roommates of similar disabilities. Staff live in the same building and 24-hour supervision is provided. The apartments are accessible to public transportation as many LD people cannot drive.

These programs are:

Chapel Haven, 1040 Whalley Avenue, New Haven, CT 06516 (203-397-1714). A maximum of 37 LD residents, age 18-30, live in two-to-four bedroom apartments in a contemporary brick building. Privately funded. Founded in 1972 by parents of developmentally disabled children attending Maplebrook School in Amenia, N.Y. The directors are Jeanne and Ronald Bercowitz. Jeanne Bercowitz was interviewed.

Jewish Special Young Adults (JESPY) House, 65 Academy Street, South Orange, N.J. 07079 (201-762-6909). A maximum of 21 LD Jewish adults, age 18-30, live in apartments, each containing three, four, or five people. Jewish identity is encouraged as a tool to help the resident develop self-confidence. Privately funded. Founded in 1978 by parents of LD children in Camp Ramah in N.Y. Carol and Steve Goodman are the directors. They were both interviewed.

Success Through Independent Living Experience (STILE), MACLD Apartment Residence, 1501 Park Avenue, Asbury Park, N.J. 07712. (201-774-4737). Two LD residents live in each of the nine garden apartments. They are 18-26 years old. Privately funded. Founded in 1979 by Monmouth County ACLD. William Buff-ton is the director, and he was interviewed for this article.

Terry's Residence for Young Adults (TRYA) Hostel, 14 Elk Street, Hempstead, N.Y. 11550 (516-481-3833). Thirty-one residents live on the second floor of a three-story apartment. Non-disabled tenants live on the other two floors. Residents have learning disabilities and mild mental retardation, a combination which works well, according to Ann Shields, its director. It is funded by a combination of state and private funds. The clients pay half of the tuition from their social security income or competitive employment. The State of N.Y. matches that amount. Parents are not required to pay tuition. Founded by Nassau County Chapter of ACLD. Ann Shields is the director, and she was interviewed for this article.

In these homes, activities of daily living such as cooking, budgeting, cleaning, and shopping are systematically taught. For example, at Chapel Haven, each person is responsible for cooking for the other people in the apartment for a week at a time. Using a detailed cookbook, in which each step is carefully explained, a counselor

shows the resident how to cook a certain recipe. The resident then cooks it while the counselor watches, telling the resident what to do, but not doing it for him. The student slowly learns to cook independently without supervision.

Naturally, the residents are motivated by the fact that their housemates are depending on them to cook well. "Occasionally, I've eaten burnt spaghetti or toast," said Falbo. "But usually, they do a pretty good job."

Cleaning is taught similarly. One night each week, the residents learn to do housework. Chapel Haven has developed a task analysis of each chore. The equipment needed is listed, followed by what the resident needs to know. Each step that the resident must be taught is listed. For example, to vacuum, they are taught to: 1) Plug in the vacuum; 2) divide the room into four equal parts; 3) remove furniture from $\frac{1}{4}$ of the room; 4) turn on vacuum; 5) beginning along a wall, push vacuum in a straight line up and back; and 6) continue pushing vacuum up and back, moving it sideways 4-6 inches with each thrust, until the rug on this $\frac{1}{4}$ is completely free of dirt and paper.

Residents assume more and more responsibility for their chores until they can do them alone. For example, in the STILE apartments, residents go to the bank to pick up their \$20 weekly food money. They shop with their roommates once a week, plan their menus, and cook their food. They also do a job that is needed by the apartment house, such as sweeping the driveway or cleaning the office.

Jean Meehan, a 20-year old resident, described a meal which the residents prepared together. "Each person made a part of the meal. I cooked the frenchfries and put them in hot oil. One person made hotdogs and hamburgers. One person made the potato

salad. We ate on the kitchen table in the office."

Meehan knew how to cook and clean before she moved into the STILE apartments. She had lived with two of her sisters. "I knew most of that stuff before I got here," she explained. "But here, I've learned how to get along with people; how to make friends. Before I came here, I can't say I had true friends. Bill (the director) helped me. I had a session with him by myself and we talked about how to start a conversation and how to talk to a person. We rehearsed conversations."

Social skills need to be taught in the same structured way that academic skills and independent living skills are taught. Learning disabled people don't always receive the correct information through their senses and might act inappropriately. For example, she might hear an angry tone of voice instead of a joking tone of voice and reply furiously. Or she might not know how far away to stand from another person because she doesn't see distance.

Residents are taught these skills in many ways. Most group homes have socialization groups where the residents meet and are taught the various skills. A counselor might roleplay with the resident and let him practice asking a friend out for a movie or discussing the latest football game. Residents learn to make small talk at parties or enter and leave a group of people who are conversing.

Ann Shields, who directs TRYA, explains, "We have groups for personal effectiveness training. We teach communications skills and eye contact. Many of the learning disabled and high-functioning retarded can't communicate what they feel. They don't have words for their emotions. Their tone of voice is inappropriate. They interrupt and say the same thing over and over again.

"We help them to improve their self-control. For example, we have office hours. If they come to ask us a question at another time, we try to refocus them and say, 'Is this an emergency? Can it wait until office hours?' Of course, sometimes, it takes longer to refocus them than it would to answer their questions."

Arguments that occur between roommates are used to teach constructive ways to deal with conflicts. For example, in TRYA, when residents meet to resolve problems, a counselor might sit behind a resident, coaching him on what to say. For example, he might whisper in the ear of a passive resident, "You told me you were angry when Ann borrowed your bread without asking your permission. Do you want to talk to her about it?"

Carol Goodman, At JESPE House, explains, "If there is a difficulty between two residents, we encourage them to work it out themselves. We want them to be as independent as possible. If it's a big conflict, beyond the resident's capacity to handle, we sit them down and help them work it out. We get them to define the problem and come up with a mutually acceptable solution. We have the typical kinds of conflicts that happen when people live together, conflicts about sharing space, about food, maybe someone uses someone else's towels. Sometimes personalities don't mesh. Or there's competition for a boyfriend. Once we had two girls seeing the same boy and he was seeing both of them. We had a love triangle going there."

Shields explained, "We have some romances here. I wish there were more. It's a great motivator. They decide they want to clean their apartment because their friend is coming over. They want to learn to travel so they can go visit them. They want to cook, so they can cook meals for them. We've had several marriages among



(At left) Susan Sellers, a resident of the MACLD Apartment residence for Learning Disabled Adults in Asbury Park, N.J., is interviewed by project director, William Buffton. Part of the project is keeping the residence clean (bottom, left). Part of independence training is knowing how to shop. Below, middle, several residents try their hand at it. And below, Jean Griffin, a resident registered nurse, discusses health factors with resident Eileen Sheehan. These photos are by Leo Choplin of Black Star.



people after they leave the program."

At TRYA, residents do many organized activities: sightseeing, attending plays, visiting museums, and going to bars and discos. "There's a lot of peer pressure to behave appropriately and not to stigmatize the entire group, when they're on these trips," said Shields. Residents also attend a coffeshop at Hoffstra University for adults with developmental disabilities. The group homes have organized recreation to widen horizons, provide further social opportunities, and for good old-fashioned fun.

Parents are an important part of the social networks of each resident. They often visit. According to Shields, "We tell the parents to treat the young adult like an adult. Don't just drop in. Let them know you are coming. Don't clean up or make curtains. We've had occasional problems of trying to teach residents to clean and then finding Mom there with a broom or a mop."

The transition from dependence to independence can be rocky for parents and children alike. The directors of residences felt that supporting the families during this transition was an important challenge. Carol Goodman is a family therapist and she often sees the parents and the client together. She explained, "When we have the cooperation of the family, we have an easier time helping the child move out. When the parents aren't clear, it makes it that much harder."

Shields explained, "To help with the letting go process, we educate the parents about the client's real abilities. It takes time and support and commitment. It takes time for adjusting. You don't force the issue. That raises all sorts of defenses."

Buffton felt that the parents tended to be overprotective. "It's hard to deal with the families. While they need to be involved, they have to know that I run the show. The families hang on to

their kids like crazy. One girl was scolded because she bought her own clothes. When a parent is overprotective, we document what we're seeing and present the parents with the facts. Sometimes, it takes a lot of jawboning to persuade them. Parents need to understand the role of the person who helps their child become independent. Sometimes the helper will seem to be an adversary."

Buffton works with the residents to help them with another challenge in learning to live independently, helping them find a job. For example, Jean Meehan, a resident was evaluated through the Division of Vocational Rehabilitation. They suggested that she become a nurse's aid.

According to Buffton, "When they suggested that, she lit up like a Christmas tree. She was really excited, because her older sister is a nurse, and she had never thought she could do a job like her older sister." Buffton called an area hospital and told them about Meehan, emphasizing her strong points. They told him to "bring her over" so she could be tested. She passed the test and is now working from 3:00 P.M. to 10:00. From 3:00-5:00, she takes classes on how to be a good nurse's aid.

She loves her work. Meehan stated, "I like it when people say 'thank you' after I do something. Making people feel good makes me feel good."

Upon arrival, clients are evaluated. Careful assessment of strengths and weaknesses is important for everyone, but it is especially important for people with invisible handicaps. Too often, they find jobs that are in their area of disability, as did the young lady with an auditory sequencing handicap (difficulty hearing sounds in order) who found a job as a telephone operator through the classified ads. Obviously, she did not succeed in the job.

At STILE, most residents are evalu-

ated through the Division of Vocational Rehabilitation. Chapel Haven has a prevocational class. Residents work at Chapel Haven doing a wide range of activities, including building maintenance, clerical tasks, stocking, packaging, and distributing food. They work for brief periods outside of Chapel Haven also, doing assembly work in a factory, fruit picking, clerical work, and farm work. Twice a week, the classes work at a local supermarket, packaging, sorting, weighing, pricing, and stocking. The teacher/evaluators watch the residents to see their strengths and weaknesses. They work with the residents to improve their weaknesses.

The next step is finding a job. According to Goodman, "Finding the right job for people is a big challenge. As the economy gets worse, we're having a harder time. Two-and-a-half years ago, it was better. We'd go to big companies, and they'd open up a job. Now they tell us that they're laying people off. We use our board contacts to find jobs. If they hear of something or if there is something in their department, they tell our vocational specialist. She follows up on every lead."

Residents also try jobs to see if they would like them. They might volunteer or try short term or part-time jobs. At Chapel Haven, each resident does several "work-study" experiences until the counselor and resident identify an area where the resident has marketable skills.

Learning disabled people are then helped to find a permanent job. A counselor helps the resident to develop a resume, look through want ads, call prospective employers, and be interviewed. The counselor also contacts employers that she knows.

After a job is found, the work of the staff is not over. Followup is necessary. Learning disabled people often take longer to train than other workers.

Sometimes, an on-the-job training can be arranged, in which the government pays part of the employee's salary during the training period. Residents sometimes need extra help with social skills and being able to adjust to work.

"At a certain point in the job process, the thrill fades," explained Shields. "They think 'Gee, I have to get up every morning at 6. And it's snowing and I have to go to work anyway.' " The realities sink in. Counselors help the residents overcome these feelings and to be proud of their work and their paychecks.

Chris Falbo enjoys his job as a utility worker. He cleans pots and pans and mops floors at a local restaurant. "I like the people I work with," he explained. "They are friendly and helpful. The bus ladies helped me with the busing. They made a few suggestions that would help me speed up a little. I used to take the garbage off the trays by hand. Now I take the silverware off and dump the garbage."

Much effort on the part of staff and residents occurs before Meehan and Falbo can learn to live independently and work productively. The four residences for learning disabled young adults have helped many clients graduate into their own apartments.

The residences began when parents became concerned about their children who were graduating from high school with no direction in their lives. Irwin Luckman, parent of an LD son, explained, "When the LD youngster is in school, he has a niche. It usually is not a good niche. He is made fun of by peers and not taught by teachers, but the point is that he is put aside for awhile. When he is out of school, he is in a situation where he is dependent on his parents. The burden on the parents becomes extremely troublesome and there's conflict. When he grows up, he is expected to leave home and start his own life, but he isn't equipped to do

that. He needs assistance in how to become independent."

Once the idea of a residence was formed in the minds of some of the leaders, the parents met among themselves, set goals, and made contacts among community members. The first problem they faced was raising the start up money. Monmouth ACLD purchased a building so that STILE could begin. JESPE house raised its money among the Jewish community. In some cases, the parents purchased the house themselves.

Zoning problems were usually avoided by moving into "Business/residential" areas. They found locations with transient populations.

Buffton makes the following suggestions:

- "Pay the taxes. Don't become tax exempt. City Councils can be very flexible if money is coming in. We started with a very low profile, only having four people move in at a time. We cut the grass of the lady next door. Every chance I get, I rap with people about what we're doing and why.

- Don't cut corners. Don't go after free accountants and lawyers. They deserve to be paid and they'll do a better job if they're paid. Don't cut corners on furniture. It will take a terrible beating.

- Go for private funding. State funding involves a lot of redtape. A lot of the rules are contrary to the concepts of normalization. For example, the state has to know how much money each resident has saved.

Shields, on the other hand, feels positively about the state funding of TRYA. "We just finished a state audit," she stated. "It was nervewracking, but the audit team was very interested in client welfare. They talked to 6 to 8 clients and asked them questions. They checked over each apartment carefully for safety. And they made some good suggestions to us about how we

handled our money. They showed us how we could set up the books, so that we had better controls over the food and budget money that we give the clients."

Her suggestions for people beginning homes? "Use the community well. I'm always amazed by the amount of help we get just by asking. For example, we have a doctor who sees our residents and accepts medicaid reimbursement for them, which is below the market rate. He serves on some of our committees. A pool table and a pinball machine were donated to us.

"The parents are a terrific resource. They do a lot of fundraising. They are willing to be available to the whole program and aren't necessarily only concerned about their own child. They've held a dinner dance and sold chance books."

Not all parents can realistically expect to be able to buy or rent a residence and develop an entire program. A less expensive alternative has been developed by Arlington ACLD in Virginia and Janis DePoy.

The Partnership Plan for Independent Living does not involve a particular building. Instead, each parent of a developmentally disabled child, rents a two-bedroom apartment. One bedroom is for the developmentally disabled client. The other bedroom houses a "partner" who serves as a role model for the client. The partner cooks several meals a week with the client, teaching him how to cook, and teaches other independent living skills as needed. The partner takes the client out for a least one social outing a week and provides companionship and support when he is with the client in the apartment. The partner receives room and sometimes board.

Depoy provides professional knowledge. She interviews the families and

(Continued on page 28.)

Women And Rehabilitation

The Mary E. Switzer Seminar of 1981

An Overview

Kathaleen C. Arneson

My reasons for writing this article are twofold. First: I wish to encourage all readers of *American Rehabilitation* to beg, borrow, or buy a copy of the proceedings of the 1981 Switzer Seminar.¹ It is a unique collection of ideas and facts from which all of us in rehabilitation, I believe, can draw much of value. The topic is provocative, and it was difficult to choose excerpts for presentation here from the smorgasbord of fascinating facts, shrewd insights, and exciting recommendations contained in the papers, the comments of scholars, and the recommendations offered.

The authors include well known researchers and writers: Dr. Carolyn Vash on "Women and Employment," and Dr. Bobbie J. Atkins on "Women as Members of Special Populations in Rehabilitation." Public rehabilitation administrators will welcome the presentation of their colleagues Martha Carrick and Tamara Bibb on "Disabled Women and Access to Benefits and Services." Joan Barker's paper on "Women as Leaders in the Field of Rehabilitation" contains a remarkable array of facts ranging through the variety of influences in society which affect leadership and women's capacity to lead in an environment that has not been friendly to this objective. The international paper by Dr. Denise Tate

contains a description of little known and shocking neglect of disabled women in many countries.

My second reason for writing this is to pay a public tribute to Mary Switzer, a rehab leader whose life, career, and friendship were an inspiration to thousands of people—people with disabilities, community and state rehab workers, students and teachers in university programs who are training future leaders, researchers and writers who are trying to illuminate new and better ways to forestall or correct the handicaps of impairment, members of legislative bodies, religious leaders, international rehab leaders, and architects and inventors who could use their talents and leadership to improve the lives of disabled people.

The Tribute

Ten years after Mary's death, it is not unusual at rehabilitation meetings to hear her friends and colleagues speak about her, and mention the growing numbers of young and mid-career people in rehab who never knew her—who were not touched or challenged by her. Invariably, the talk gets around to reminiscing about personal experiences with her. We recall her charm, her vitality, and her warmth. We recite evidences of her leadership qualities and the anxiety some of us

experienced while presenting before her an idea or a new program for approval (Her capacity for spotting weakness in facts or analysis was well known!). We remark on her political sagacity. Some remember and speak ruefully about her courting of people with wealth and/or position because she understood and needed their influence on public policy decisions to move forward on some new idea or program that would benefit handicapped people.

Recently, such conversations move into observations and expressions of apprehension about prospects for maintaining the momentum of the rehab movement. How can gains be preserved in the face of budget constraints at all levels of government? What can be done about the current federal administration's drive to reduce federal funds and national leadership in rehabilitation, education, and other public programs that make possible and undergird the capacity of disabled people to become trained, employed, and maximally self-sufficient despite their impairments? What would Mary do if she were confronted with today's problems when rehab seems to be on a down curve with the rest of the people-oriented programs?

Currently, within professional rehab circles and among the consumer groups

we find also, growing expressions of concern about the effectiveness of many long held rehab policies and practices and organizational arrangements for providing services. We find consumer groups pushing for their greater involvement in rehab policy-making. Informed Congressional and other legislative leaders remain staunch in their support for services and the rights of people with disabilities—but they, too, are being pressed strongly to justify costs of maintaining service levels and standards for ever greater numbers who need and can benefit from inclusion in the benefits of the programs.

Choosing the Topic

In this climate of concern, and disposition toward greater program evaluation by many sectors of the rehab movement, the Switzer Memorial Committee began discussion of several ideas for the 1981 seminar. One that surfaced early and was chosen after considerable discussion about ways to put it in focus was the theme of “Women and Rehabilitation.” The seminar’s Planning Committee decided upon a broad definition of the topic. It would include a two-pronged approach: women as providers (leaders) of rehabilitation services and women as recipients of services. The key issues raised by the committee reflected both opportunities for women and barriers which exist to their most effective participation in the movement. Each paper, therefore, incorporates different degrees of both emphasis. The Planning Committee also recommended sub areas for exploration by authors and the names of authors and scholars who were qualified to address these topics and who could do so within the limited time available to develop adequate working papers.

Near final drafts of these papers were sent in advance for review and

comment to each of the 20 scholars selected for the 1981 seminar.² A word needs to be said about the scholars. More than a hundred women were recommended to the Switzer Committee for participation in the seminar. The wealth of experience and judgment represented by this collection of women now in leadership roles in rehabilitation is enormous. Choosing a representative group of 20 from the representative group of 100 was very difficult.³ It meant losing much valuable expertise stemming from the careers of scores of committed workers currently testing, refining, and extending many of the principles developed by Mary Switzer and her colleagues and those who began the movement more than 60 years ago.

As we worked to define the key issues of the general theme, the Planning Committee had the guidance and participation of experienced Switzer Committee members. These included Olive Bannister, Brock Schumacher, Jim Burrell, and Len Perlman—coordinator for the committee and editor of the proceedings of other Switzer seminars.

Within a remarkably short time, the seminar process was underway, culminating in a 3-day seminar at Galaudet College in Washington. President Edward Merrill, Mrs. Merrill, and staff were generous and supportive hosts for the working sessions and the reception for scholars and Washington rehabilitation leaders.

The Welcome by the Assistant Secretary for Special Education and Rehabilitation Services:

Jean Tufts, the Assistant Secretary who is concerned with education for handicapped children and rehabilitation, welcomed the scholars. They responded to her gracious manner and to her keen perception of the essence of Mary’s national leadership. I quote some of her comments:

“Mary Switzer realized that politics played as much a role in the decisions of leadership as did theory, tradition, and expediency...She expanded the range and scope of rehabilitation tremendously. She built a ‘therapeutic empire’ that helped millions of otherwise wasted individuals with potential. She formed political alliances based on the needs of disabled persons, alliances which promised security and continuity in funding and services. She learned—and practiced—the art of politics, an art that rarely has been equalled in the ‘Washington Scene.’

“....The spirit and determination of Mary Switzer is still very much alive in the building named for her in Washington, D.C., and her traditions guide us immeasurably in our daily work....I welcome your revitalization of the spirit of Mary E. Switzer....I welcome you to Washington and the inspiration that Mary Switzer gave us all to break through the earlier traditions of our field to find the golden nuggets of change underneath....”

The Discussion Papers

Women and Employment

Carolyn Vash’s paper examined the employment status of women with disabilities in order to plan future corrective action...From her marshalling of data and its interpretation to seminar participants evolved findings, recommendations, and implications for action. They saw the employment situation as *bleak*. Some excerpts are:

- The largest problem confronting disabled women and other employment seekers is a glutted employment market.

- 8.5 million women report disabilities and such disabilities have more negative effect on women’s employment than they do on that of men.

- There is concern that many women are placed into stereotyped jobs because of the training they re-

ceive; because they have no idea of what jobs may be available in their community; or they don't know what they might be able to do best.

- Significant groups who are often screened out from acceptance into the service delivery system are disabled female, ethnic minority, and aged.

- Some corrective actions would be realistic screening that ensures acceptance into vocational rehabilitation programs; better training of counselors and others entering the rehabilitation professions; sensitization training for employers and unions on equipment modification for disabled women; education in flex time, job sharing/part time jobs for those disabled women who need adjustable hours because of limited physical capacities and/or home responsibilities; education of the general public, the media, and candidates for public office about disabled women, their needs and potentials; and improving job hunting, outreach to the networking with groups representing specific occupational groups (lawyers, bankers, media) and general groups (Republicans and Democrats).

Disabled Women and Access to Benefits and Services

The authors, Carrick and Bibb, reviewed early American legislation to benefit women and found that, historically, federal legislation was assigned to protect the female in society, primarily in her role as a nonwage earner. Major excerpts from their paper are:

- The women's movement has only recently begun to have an effect on the availability of expanded benefits, education, and employment for women.

- Societal changes, such as need for women to work and larger numbers in the work force, have not been reflected in the expansion of benefits and services to women for increased independence, either financially or socially.

The track record is even more dismal with respect to disabled women:

- Civil rights legislation and programs should be sustained and fully implemented at all service delivery levels, in all areas: education, health and rehabilitation services, and medical and social services.

- Educators and people in medical and allied health professions need sensitization and should be provided information about unique aspects of service to disabled women.

- A three-pronged educational effort should be initiated: to disabled women to inform them of rehabilitation and other services and benefits available to them; to rehabilitation counselors to help them understand the needs of women with various disabilities and the service community resources available to assist in service delivery, and to other community service providers to inform them of the needs of disabled women.

A strong recommendation was that there should be required studies relating to disabled women's access to national benefit and service programs. Programs listed included all social security programs, vocational rehabilitation programs, CETA programs, Work Incentive and the many other Department of Labor programs, including Workmen's Compensation.

Women as Members of Special Populations

The lead sentence in Dr. Bobbie Atkins paper is "Contemporary American society is faced with the compelling challenge of assisting women, as members of special populations, to maximize their potential in order that increased participation in all aspects of society become a reality." Other excerpts and ideas are:

- Many members of majority America continue to be oblivious to the fact that everyone's life styles, per-

ceptions, and values are not the same as their own. Special populations of women, she states, differ in roles and expectations from their majority, able-bodied female and male peers. Special population women have suffered from the same ramifications of sexism experienced by all women. Minority and disabled females have suffered from the negative impact of discrimination based on their color and/or disabilities....

- For the woman who is disabled and in a minority, self definition involves a triad process. First, all the negative aspects concerning female status previously cited must be clarified. Next, the stereotypic descriptions associated with minorities must be considered. Finally, the realities of the internal and external obstacles of physical and/or mental disabilities must be confronted. The impact of disability, of minority status, and of being female can produce major impediments to self actualization.

The author notes that male awareness and traditional male views of the female as a dependent person who relies on him for direction and support affects the capacity of men to accept the humanness of women....Traditional male and female attitudes regarding the role and status of women have prevented meaningful resolution of many problems for women. For disabled and minority women, these attitudes are reflected through discrimination in all aspects of society, suggesting that multifaceted resolutions must be considered. Social conditioning is felt to be at the root of the attitudes held by females and males representing a critical barrier still to be confronted and overcome.

Education is viewed by Ms. Atkins in these terms:

".....To plan effectively for assisting special populations of women in rehabilitation, increased awareness by re-

habilitationists of both the opportunities and obstacles in education is a must. Specifically, accessibility for and acceptance of special groups of females in education must be explored. Additionally, rehabilitation workers must examine their attitudes concerning educational opportunities for females. Schools and colleges have increased the availability of education services for females, but convincing some females and their male peers that they are deserving of these services may be an overwhelming challenge..."

The author stresses the importance of social-economic status as it relates to education, employment, and quality of life. She believes that it cannot be overstressed and the seriousness of these relations is particularly salient for minority and disabled females. Racism and sexism decrease the quality of education and, in turn, restrict economic opportunities and the ultimate quality of life....

- The complexities associated with being a minority and/or a disabled female are serious but not insurmountable. Needed is a creative use of existing resources and the development of new approaches based on individual and group needs of women. The following mechanisms may be employed to assist special groups of females within and outside of rehabilitation: Self actualization/self definition; reinforcement/support; skill acquisition/refinement; and implementation/action.

Leonard Perlman, the seminar coordinator, noted that there exists a need to develop an innovative program of outreach to disabled women of ethnic minorities, who are not aware of services and rights to participate and are often totally excluded from entry into the service delivery system. There should be some assurance that policies are in place to monitor discrimination to ethnic minorities, with

particular focus on discrimination against older disabled women, women who are deaf, and disabled women in rural communities. He highlighted a finding that research in the delivery of services to disabled women of ethnic minorities is needed: the special needs of subgroups within the culture, such as the difference among Spanish speaking people, among American Indians, among Asian people....

Women as Leaders in the Field of Rehabilitation

Joan Barker's paper records the names of many women who played significant parts in the conceptualizing of the rehabilitation process and in promoting and implementing a creative, ever expanding vocational rehabilitation program. I hope readers will add to the lists of those mentioned. We can be sure that many more played key roles in individual states and localities and in special rehabilitation areas.

One group inadequately referenced because of time and data limitations are the volunteers in rehabilitation. There are hundreds of men and women—especially parents—who have advocated for the establishment and extension of habilitation and rehabilitation services for people who are retarded. Additionally, scores of women serve in civilian and veterans rehabilitation centers and hospitals. Many women on public and voluntary advisory and policy boards are making, affirming, and guiding the development of civic awareness and support of the needs of disabled children and adults.

Barker assembled statistics and other data on an enormous variety of relevant subjects dealing with the status of women and their leadership potential: civil rights, economic status, demographic trends, salaries of women in rehabilitation agencies, the educational and cultural development of children and women, including train-

ing in the mechanics of leadership and leaders in action.

Focusing on women in leadership roles, one of the seminar participants emphasized Barker's stress on training of staff and the general public.

- There should be a concerted effort to emphasize leadership training in the curriculum of educational facilities.

- Two areas which could lead to improvement in the status of women are networking and role models. Networking is being widely used by women executives and business women. A rehabilitation network could be influential in job upward mobility.

Shelia Hackett, in reviewing the Barker paper, said:

- A most valued implication of the author's research is for the disabled woman who truly needs objective information in vocational planning. Since the disabled woman needs to participate fully in her own vocational rehabilitation planning, this article could be used in orientations to newly disabled women; in training packages with public and private agencies who service disabled women; and in conferences with the National Rehabilitation Association, local chapter conferences, and governors committees on the handicapped meetings and workshops.

I agree with these and would add that this paper and the essence of the other papers from this seminar should be used by the great national women's civic, professional, business, and social organizations. These groups, especially those on the Womens' Committee of the Presidents Committee on Employment of the Handicapped, will find in these papers a wealth of data, preparing people for the rehabilitation professions. Such training should include courses in assertiveness training, supervisory skills, personal interaction, business administration, and public relations. Training techniques should

include exposure to small and large groups where the concepts of leadership, authority, power, and roles and responsibilities can be studied experientially.

- As noted by Elizabeth Minton, only a few women have been leaders in the field of rehabilitation, but the impact made by these few was far-reaching and significant in shaping rehabilitation. We need to analyze, learn from, and promote the qualities and actions which led to such outstanding leadership.

- Since the 1977 study on women in rehabilitation, there has been a significant increase in the number of women counselors and supervisors helpfully leading to administrative positions. Now is the time to develop curricular and training programs which will deal with the implications of the study findings: professional identification, attitudes toward success, and perception of the importance of money and status. Points of view, findings, concerns, and recommendations about women who have impairments and who need the active attention of women's leadership groups to help improve opportunities for disabled women and lessen the barriers before them.

Women and International Rehabilitation

The introduction to Dr. Tate's paper contains shocking facts about disabled women in most parts of the world. They are highlighted by the assembled data on opportunities and barriers for women as they relate to food, status in the community, education/training, employment, health and/or disability, and benefits and services that are available (usually *not* available) to them, as well as to those who are able-bodied. Dr. Tate notes the scarcity of references or research data regarding the theme of disabled women and their status in other countries. She says

that this scarcity of resources reinforces the assumption that in the U.S. and especially in the less developed nations of Latin America, Africa, and Asia, very little attention has been paid so far to the female who is also disabled.

Other excerpts from the introduction follow:

- Poverty and low status of women are major contributors to disablement. In the developing countries, where 80 percent of the world's disabled population lives, one of the major causes of disability is inadequate nutrition of mothers and children, especially girls. As a 1981 report from the International Labor Office points out, this vicious circle is further perpetuated by the fact that, in certain parts of the world, a baby girl receives only the food left by her father and brothers. Such cultural customs weigh even more heavily on disabled women who tend to age more rapidly when the harvest is poor and food is reserved for the young and healthy.

- Socially most women have been conditioned by the family and society to want less in life than men, to be content with service-giving types of work and activities. Discriminatory barriers against women exist in almost all cultures. These deeply rooted traditional attitudes limit women's opportunities for self-improvement and deprive human society of women's maximum contribution in development and in public services.

Added to the problems of illiteracy and poverty, a disabling condition may become an insurmountable barrier for many females in the world. This is especially true of women living in less developed countries where resources are very limited and almost no support is offered to disabled people. Many disabled women around the world are discriminated against on several grounds, each of which limits their options and opportunities for

participating in economic, social, and political life and in obtaining an education.

In reviewing this paper, one of the scholars, Billie Elder, noted "The backdrop against which the scenario of international rehabilitation was presented is so dark that it appears overwhelming. We must struggle to change our mindsets in order to understand the full spectrum of the needs of women who have been pushed down so long and denied the nutritional, medical, educational, and social opportunities and services that we so often take for granted...." She goes on to ask questions about the relative amounts of American foreign aid which many Americans feel has been very generous. Are they looking only at the totals that include armaments rather than these dollars, and other resources that are assigned to women and girls in refugee camps? She speaks about the fact that the International Women's Year and the International Conference on the Situation of Blind Women dramatized the status of women in various countries. She asks if the United Nations and the United States are aggressively pursuing the recommendations of these conferences. Elder also believes that the media and our own governments have not emphasized the International Year of Disabled People as they should. She asks if this is due, at least in part, to the lack of full participation of associations, councils, and federations of disabled persons.

The author states that a major obstacle in improving the status of women lies in public attitudes and values reflected by the mass communications media concerning women's roles in society. The same principle applies to images of disabled people projected by the media. Recently....a greater exposure has been given to this theme, thus building greater acceptance of the

disabled in general.....The need exists to fight.....barriers if disabled women are to be treated differently from what Castle refers to as second class citizens entitled to third class benefits....

Speaking of this paper, another author, Carolyn Vash, said "I don't know that it belongs in this particular paper, but I was constantly reminded while reading it that we have a sizeable number of 'third world nations' within our own country—e.g., the Navajo Nation, to name only the largest—wherein the status of women requires massive attention. Women migrant farmworkers constitute another group that has been given far less attention than is deserved. In rehabilitation circles, the phrase 'It's easier to place a quadriplegic with a college education in a job than a migrant farmworker with a successfully repaired hernia' has become the cliché illustrating the supreme difficulty entailed in rehabilitating women or men who lack education, language skills, entrenchment in 20th century culture, and access to even the available support systems. If the author has available information on such American subpopulations, its inclusion could be a valuable addition to this paper. If not, perhaps these issues can be addressed in a future seminar."

I hope this selection of excerpts and quotes from the papers and discussions at the Sixth Mary E. Switzer Memorial Seminar will stimulate further discussion, much more research on women and rehabilitation, and *action now* on those issues and suggestions which are ready for such attention.

Dr. Dan McAllees, President of the NRA, said it succinctly:

"It is our sincere hope that policymakers, legislators at all levels of government, and rehabilitation specialists of all types, including rehabilitation personnel in training, will take more

than a close look at these findings and implications. ACTION is needed now and more than rehab is at stake."

Mrs. Arneson is a consultant in rehabilitation. For 20 years, she was legislative director and congressional liaison for RSA.

Notes

1) The 1981 Switzer Seminar. The Switzer Memorial Fund (Monograph 6), National Rehabilitation Association, 633 S. Washington Street, Alexandria, Virginia 22314. \$10.

2) The conference participants were: Edna Adler, Kathaleen Arneson, Bobbie Atkins, Joan Thompson Barker, Martha Carrick, Susan Flowers Dixon, Billie Elder, Yetta Galiber, Sheila W. Hackett, June LaCatta, Chris Lord, Frances Lowder, Elizabeth Minton, Thelma Schmones, Ber-

nice Sherman, Harold Snider, Miriam Stubbs, Denise G. Tate, Evelyne R. Villines, Carolyn Vash, and Martha Lentz Walker.

3) Skills, experience and insights of the 20 were varied: Personal experience with chronic impairments; teaching; administration of rehabilitation programs; advocacy for women's rights; TV and media planning; organization of community efforts; employment planning for disabled women; developing and managing inner city information and referral services for minority handicapped people; labor market analysis; politics and federal legislation; civil rights advocacy; volunteer opportunities for handicapped people; university research and training; regional and Washington experience in administration of the state-federal vocational rehabilitation programs and independent living.

INDEPENDENT LIVING

(Continued from page 22.)

recruits several possible "partners" for the parents and client to interview. She trains and supervises the counselors and provides backup in case of crisis.

"The beauty of this program," explains DePoy, "is that it's flexible. The parent and the resident choose the location of the apartment and the partner, and we teach whatever skills need to be learned."

Annette Goldreyer, of Arlington ACLD, explains, "The program is still experimental. There have only been two attempts so far. We hope for feedback from anyone who uses this plan or any other. There is a dire need for exchange of information as all of us know." She has offered to collect this information for Partnership Plan for Independent Living; her address is 3851 North Upland Street, Arlington, VA. 22207.

Some other ideas for training learning disabled adults in independent living include:

- From youth, be sure your child participates in family chores such as cooking, cleaning, and laundry. Teach him how to shop, to budget, and to wake up independently at the proper time. He should be a productive part of family life.

- Tutors are often hired for academic subjects. If you don't have the time or inclination to teach your child, why not hire someone to do it. You could advertise the job in the newsletter of ACLD or ARC and find a professional or relative of another LD person.

- Find someone to teach the parents in your parent group some new ways to teach these skills to your children. Perhaps a parent who is training her own child could share her ideas with everyone else.

- Make sure that home economics is included in your child's individualized educational plan.

(Continued on Cover III.)

NEWS, NOTES, ANNOUNCEMENTS

Famous Deaf Actor Becomes Superhero In New Videotape

Internationally known actor and director Bernard Bragg has completed a new videotape being produced by the Multi-level Captioning Project at The Caption Center, WGBH Boston. The 15-minute videotape is designed especially for deaf children, and uses animated letters and live action to introduce students to the many elements of TV captioning. Bragg is featured as "Caption Marvelous," a superhero who teaches two deaf children how captions can open a new world of understanding.

The "Caption Marvelous" videotape grew out of the Multi-level Captioning Project's years of research. "Our studies showed that despite the boom in captioning for deaf children, the kids themselves are often confused by words on the screen, and sometimes fail to connect them with spoken dialogue," says Betsy Montandon, Multi-level Captioning project supervisor. "Thus we feel it's important to start at the beginning and teach deaf students exactly what captions are." She is enthusiastic about the recent taping. "Bernard Bragg's talent and personality really came through. He's a definite plus for the project."

The videotape will be accompanied by a workbook for students which illustrates the points made in the tape. In addition, the Multi-level Captioning Project is producing two other components for a planned "Caption Kit": a comprehensive teachers' manual that includes ways to use captioned media in the classroom and

dormitory and a brochure for parents that briefly discusses the skills deaf children need in order to get the most from captioned materials. The three-part Caption Kit will be available in March 1982.

The staff of the Multi-level Captioning Project is available for workshops and consultation to schools and other organizations serving the deaf on a variety of topics related to captioned media, including a demonstration of the Caption Kit. "Caption Marvelous" videotape is being coproduced by Envision Corporation of Boston. The project is funded by a grant from the Office of Special Education, U.S. Department of Education. For more information: Betsy Montandon, Supervisor, Multi-level Captioning Project, The Caption Center, (617) 492-2777 (Voice), (617) 491-5724 (TDD).

—This article is based on a story carried in *Vibrations*, Social Services for the Hearing Impaired, Inc., Flint, Michigan.

Four Sites Test Disabled Youth As Volunteers

The National Center for Citizen Involvement has initiated a 3-year grant received from the W. K. Kellogg Foundation to develop a program entitled Citizen Volunteer Involvement for Physically Disabled Youth. It will assist physically disabled youth to develop attitudes and skills for independent living through volunteering and citizen involvement.

Pilot projects were selected at these sites: the Boston School for the Deaf, Randolph, Massachusetts; Volunteer Center, Dallas, Texas; Volunteer

Services for Greater Kalamazoo, Kalamazoo, Michigan; and the Michigan School for the Blind, Lansing, Michigan.

The projects will demonstrate that disabled people can serve as full participants in their communities. Human service agencies will involve disabled students as volunteers. Special emphasis will be placed on developing an academic and experiential course within both special and public schools which will assist disabled youth and adults in understanding citizen involvement from the perspective of the volunteer and as a recipient of volunteer services.

For further information regarding the project, contact Gene Hensley, Director of Education, VOLUNTEER: The National Center for Citizen Involvement, P.O. Box #4179, Boulder, CO 80306. Telephone: (303) 447-0492.

New Publication Introduces New Workshop Name

A new approach to operating work centers serving citizens with disabilities is presented by the National Easter Seal Society in its latest publication. Illustrative of this new approach is the introduction of the term "work centers" replacing the old, familiar term "sheltered workshops." "The term 'work centers' conveys a more appropriate, positive image of vocational rehabilitation facilities," says John Garrison, Executive Director of the National Easter Seal Society.

Single copies of *Work Centers: A Guide For The '80's* (publication CT-43) may be purchased for \$5 from National Easter Seal Society, 2023 West Ogden Avenue, Chicago, Illinois 60612.

AMERICAN REHABILITATION

Content Listing

Volume 7, Numbers 1-6, 1981-82

ACCESSABILITY The Arts: A Great Resource for Disabled People	Sept/Oct	3	COLORADO Learning to live independently	May/June	3
ADMINISTRATION			COUNSELING		
Interagency committee	May/June	11	Addressing Psychological Needs	Nov/Dec	21
Handicapped By Design: Need for Printing and Publishing Guidelines	Mar/Apr	4	Computerized Placement Service	Nov/Dec	26
New Concepts and directions in rehabilitation	Mar/Apr	18	Perspectives on rehabilitation of older people	Sept/Oct	18
Legislation Affecting Rehab of SSI & SSDI Beneficiaries	Nov/Dec	12	COUNSELOR Self-actualization of rehab counseling students	Mar/Apr	30
PARS of SSI & SSDI Programs	Nov/Dec	18	DANCE THERAPY The Arts: A Great Resource for Disabled People	Sept/Oct	3
Computerized Placement Service	Nov/Dec	26	DEAF		
State VR role in developing cardiac rehabilitation programs	Sept/Oct	12	Deaf Awareness	May/June	18
AGING			Mumps and hearing loss	May/June	30
Perspectives on rehabilitation of older people	Sept/Oct	18	Deaf Employee Hears With Hands	Jan/Feb	32
Texas unit develops job opportunities for blind and visually impaired people	Sept/Oct	25	Review: Deaf Heritage	Nov/Dec	24
Role of District Nurse in Sweden	Sept/Oct	27	DISTRICT OF COLUMBIA Making Government Procurement Work For Disabled Workers	Jan/Feb	27
ALCOHOLISM The Extra Burden	Nov/Dec	3	DRIVING Handicapped Drivers Evaluation and Training	Jan/Feb	18
ARCHITECTURAL BARRIERS			EMPLOYMENT		
Access To The Skies	Nov/Dec	9	New Wave in rehabilitation: PWI Work Program Pays Big Dividends	Mar/Apr	21
ARTS "The Arts: A Great Resource For Disabled People"	Sept/Oct	3	Making Government Procurement Work For Disabled Workers	Jan/Feb	27
ATTITUDINAL BARRIERS Deaf awareness	May/June	18	Minetraining in Utah	July/Aug	7
AUTOMATION Computerized Placement Service	Nov/Dec	26	Deaf Employee Hears With Hands	Jan/Feb	32
BLIND			Computerized Placement Service	Nov/Dec	26
Blind beep ballers belt Burners	Mar/Apr	25	Texas Unit develops job opportunities for blind and visually impaired people	Sept/Oct	25
Making Government Procurement Work For Disabled Workers	Jan/Feb	27	Women in Rehabilitation	July/Aug	23
Solar Battery	Nov/Dec	31	FLORIDA Work program pays big dividends	Mar/Apr	28
Perspectives on rehabilitation of older people	Sept/Oct	18	GEORGIA Computerized Placement Service	Nov/Dec	26
Texas unit develops job opportunities for blind and visually impaired people	Sept/Oct	25	GROUPS Magnum Opus: Self-Help In Organization of people undaunted by stroke	Sept/Oct	7
CALIFORNIA			HEART DISEASE State VR Role in Developing Cardiac Rehabilitation Programs	Sept/Oct	12
Blind beep ballers belt Burners	Mar/Apr	25	INDEPENDENT LIVING		
Addressing Psychological Needs	Nov/Dec	21			
CASE HISTORIES Rehabilitating The Learning Disabled Adult	Jan/Feb	3			

Learning to live Independently	May/June	3	Computerized Placement Service	Nov/Dec	26
IL for Learning Disabled people	July/Aug	18	PLANNING Handicapped by Design; need for printing and publishing guidelines	Mar/Apr	4
INFORMATION RETRIEVAL	July/Aug	27	PRINTING Handicapped by Design: Need for Printing and Publishing Guidelines	Mar/Apr	4
INTERNATIONAL			PROCUREMENT Making Government Procurement Work for Disabled Workers	Jan/Feb	27
IYDP-A Global Perspective	Jan/Feb	14	PROGRAM ADMINISTRATIVE REVIEWS Pars of SSI & SSDI Programs	Nov/Dec	18
Role of district nurse in Sweden	Sept/Oct	27	PROJECTS WITH INDUSTRY		
IYDP			New Wave in rehabilitation: PWI	Mar/Apr	21
U.S. Report	Jan/Feb	14	New concepts and directions in rehabilitation	Mar/Apr	18
A Global Perspective	Jan/Feb	14	Perspectives on rehabilitation of older people	Sept/Oct	18
LANGUAGE			PUBLISHING		
Language Used or Used Language?	Mar/Apr	14	Handicapped by design	Mar/Apr	4
Language used of used language?	Nov/Dec	25	Preparing Manuscripts	July/Aug	10
Languaged used or used language?	May/June	20	RECLAMATION Work program pays big dividends	Mar/Apr	28
LEARNING DISABILITIES			RECREATION Blind beep ballers belt "Burners"	Mar/Apr	25
Rehabilitating The Learning Disabled			REHABILITATION New concepts and directions in rehabilitation	Mar/Apr	18
Adult	Jan/Feb	3	REHABILITATION PROGRAMS		
Living Independently	July/Aug	18	State VR role in developing cardiac rehabilitation programs	Sept/Oct	12
LEGISLATION			RESEARCH		
Legislation Affecting Rehab of SSI & SSDI Beneficiaries	Nov/Dec	12	Interagency committee	May/June	11
Legislation affecting SSI and SSDI	Sept/Oct	23	Perspectives on rehabilitation of older people	Sept/Oct	18
LIBRARIES Solar Batteries	Nov/Dec	31	RESEARCH & TRAINING CENTERS		
LOUISIANA Handicapped Drivers			Interagency committee	May/June	11
Evaluation and Training	Jan/Feb	18	Perspectives on rehabilitation of older people	Sept/Oct	18
MARY SWITZER	July/Aug	23	REVIEW		
MINING, in Utah	July/Aug	7	Women and Disability	May/June	26
MUMPS Mumps and hearing loss	May/June	30	Review: A Rose For Tomorrow	Mar/Apr	15
MUSIC THERAPY The Arts: A Great			Deaf Heritage	Nov/Dec	24
Resource for Disabled People	Sept/Oct	3	RIGHTS		
NARIC	July/Aug	27	Know your rights	May/June	8
NATIONAL COUNCIL ON THE HANDICAPPED			Registering and voting	May/June	21
Second Year Agenda	Jan/Feb	12	Women in Rehabilitation	July/Aug	23
	Sept/Oct	11	SELF-HELP Magnum Opus: Self-help in organization of people undaunted by stroke	Sept/Oct	7 31
NEW JERSEY					
Learning Disabled live independently	July/Aug	18			
NEW YORK					
Magnum Opus: Self-help in organization of people undaunted by stroke	Sept/Oct	7			
Perspectives on rehabilitation of older people	Sept/Oct	18			
NORTH CAROLINA State VR role in developing cardiac rehabilitation programs	Sept/Oct	12			
NURSING Role of district nurse in Sweden	Sept/Oct	27			
PLACEMENT					
Job Opportunities For Blind & Vis. Impaired People	Sept/Oct	25			

SEVERELY DISABLED Making Government Procurement Work For Disabled Workers	Jan/ Feb	27
SSDI		
Legislation Affecting Rehab of SSI & SSDI Beneficiaries	Nov/ Dec	12
PARS of SSI & SSDI Programs	Nov/ Dec	18
Legislation affecting SSI and SSDI	Sept/ Oct	23
SSI		
Pars of SSI & SSDI Programs	Nov/ Dec	18
Legislation Affecting Rehab of SSI & SSDI Beneficiaries	Nov/ Dec	12
Legislation affecting SSI and SSDI	Sept/ Oct	23
STROKE Mahnum Opus: Self-help in organization of people undaunted by stroke	Sept/ Oct	7
TEXAS Texas unit develops job opportunities for blind and visually		

impaired people	Sept/ Oct	25
TRAINING		
Self-actualization of rehab counseling student	Mar/ Apr	30
Handicapped Drivers Evaluation and Training	Jan/ Feb	18
Addressing Psychological Needs	Nov/ Dec	21
The Arts: A Great Resource for Disabled People	Sept/ Oct	3
Perspectives on rehabilitation of older people	Sept/ Oct	18
TRANSPORTATION Access To The Skies	Nov/ Dec	9
UTAH Mine Training	July/ Aug	7
VOTING Registration and voting	May/ June	21
WOMEN in Rehabilitation	July/ Aug	23
WORKSHOPS Making Government Procurement Work For Disabled Workers	Jan/ Feb	27

AMERICAN REHABILITATION

Author Listing

Volume 7, Numbers 1-6, 1981-1982

Abrams, Joseph	Nov/ Dec	12	Kraync, Karl	July/ Aug	7
	Sept/ Oct	23	Lichter, Stephen	May/ June	8
	Mar/ Apr	15	Lloyd, Kathleen	May/ June	26
	Nov/ Dec	24	Magee, James T.	Mar/ Apr	21
Arneson, Kathaleen	May/ June	21	Mansolo, Ron	Sept/ Oct	25
	July/ Aug	23	Mares-Dixon, Judy	May/ June	3
Atkins, Bobbie J.	Mar/ Apr	30	McCarthy, Henry	Sept/ Oct	7
Bellamy, Dallas	Mar/ Apr	25	Meyer, Ann B.	Mar/ Apr	30
Briscoe, Eleanor	July/ Aug	27	Moore, David	May/ June	8
Brown, Dale	Jan/ Feb	3	Myers, Jane E.	Sept/ Oct	18
	July/ Aug	18	Odum, Mark	July/ Aug	27
Brubeck, Thomas	Sept/ Oct	3	Ojanlatva, Ansa	July/ Aug	10
	Nov/ Dec	3	Page, Homer	May/ June	3
Conn, George A.	Mar/ Apr	18	Patek, Robert E.	Nov/ Dec	18
Decker, Roger S.	Nov/ Dec	26	Petell, Michael E.	Jan/ Feb	14
Fleming, Thomas J.	Mar/ Apr	21	Pierce, Susan	Jan/ Feb	18
Fuhrer, Marcus	May/ June	11	Powell, Judy	May/ June	3
Garza, Rolando	Sept/ Oct	25	Ralph, Jack B.	Mar/ Apr	4
Geletka, James	Mar/ Apr	21	Reida, Ellis	Nov/ Dec	9
Giannini, Margaret	Sept/ Oct	18	Richman, Charles S.	Jan/ Feb	27
Graden, Hank	Sept/ Oct	12	Sanders, Marge	Mar/ Apr	28
Hall, Bonnie J.	Sept/ Oct	27	Stone, Christopher I.	Mar/ Apr	30
Hogan, Harry A.	Jan/ Feb	18	Szeto, Andrew Y. J.	Jan/ Feb	18
Housman, Roberta	Sept/ Oct	18	Vanderwerf, Sander	Nov/ Dec	26
Hyatt, Carol	May/ June	30	Vernon, McCay	May/ June	30
Jones, Barbara	Nov/ Dec	21	Wedewer, Donald	Sept/ Oct	18

PUBLISHING

(Continued from page 11.)

topical articles which are often not accepted by other publications but which are written in appropriate English. Topical areas range from personal experiences to reactions and exposes.

The review period is a few weeks long, and once published, the author will be provided with a complimentary copy.

DISABLED USA. Editor: Robert Gourski. Address: President's Committee on Employment of the Handicapped, 111-20th Street, N.W., Room 600, Washington, DC 20036. Telephone Number: (202) 653-5078.

The publication reaches 22,000 disabled people, their employers, educators, rehabilitation professionals as well as local, state, and national officials ten times a year.

Each year 50-100 manuscripts on research, topical areas covering legislation, and programs about disability, and summaries of personal experiences, interviews and opportunities are reviewed. About a third of these are published.

Anyone interested in being an author may submit a manuscript to the editor. The submissions should be 8-10 pages long, typed, double-spaced, written in informal, conversational language with frequent use of source quotation and with a personal touch. The review period is about 2-3 months. The publication will not pay for published articles.

The author will receive a complimentary copy.

THE EXCEPTIONAL PARENT. Editors: Maxwell J. Schleifer, Ph.D., Editor-in-Chief, Stanley D. Klein, Ph.D. Address: 296 Boylston Street, Boston, MA 02116. (617) 536-8961.

The Exceptional Parent is a bi-monthly magazine, intended to provide useful, practical information in understandable language. It reaches 22,000 parents, educators of the handicapped and disabled children. The proposed articles should cover research, philosophy, or any of the following topics: learning regarding handicapped, social, physical and emotional disabilities, as well as relevant personal experiences and mainstreaming.

Approximately 10 per cent of the 250 submitted manuscripts are published annually. The mail should be directed to the Editorial Department. Any interested individual knowledgeable about the handicapped is invited to send manuscripts. The review period is about 6 months.

Material should be typed, double-spaced, and preferably no longer than four pages.

REHABILITATION GAZETTE. Editors: Gini and Joe Laurie. Address: 4502 Maryland Avenue, St. Louis, MO 63108. Telephone Number: (314) 361-0475.

Rehabilitation Gazette is an annual publication reaching 10,000 professionals and disabled people of all kinds, but with the emphasis on severe disabilities.

Submitted manuscripts should be about 800-1600 words, written in plain English, and preferably by disabled people. Articles cover research, as well as philosophical and topical areas. Examples of previously published material has included education, employment, equipment, hobbies and sports, independent living/housing, travel, and a number of other topics of interest to the audience. Any proposed material should be sent to the editors who are also open to suggestions as far as new areas of interest or departments for the publication are concerned.

Since the time of its original publication date in 1958, the *Gazette* has been a volunteer project by its able-bodied founders, editors and publishers. Staff and volunteer help consist of both disabled and able-bodied people. No salaries, no payment for articles or subscriptions exist. Readers and contributors are asked to make donations per copy (\$3 from the disabled, \$5 from the able-bodied individuals). An author will be provided with a complimentary copy.

INDEPENDENT LIVING

(Continued from page 28.)

- If your child needs full time, extensive help and you have extra room in your house, consider hiring a student to live with the family. Graduate students of special education, psychology, and other related disciplines eagerly search for jobs such as this.

Learning disabled people can learn to live independently and become productive citizens with the support of their family and the community. With the development of the independent living movement among learning disabled people, there will be many more success stories such as Jean Meehan and Chris Falbo.

"What would I have done at home?" asked Falbo. "Just sit around? Watch TV? And listen to music? Now I have learned to cook, learned to clean, and learned to budget. I have a job."

Ms. Brown is a public information specialist for the President's Committee on Employment of the Handicapped.

For a booklet on learning disabled adults, write for *Learning Disabilities, Not Just A Problem Children Outgrow* from the President's Committee on Employment of the Handicapped, Washington D.C. 20210.

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AMERICAN

September-October 1982

REHABILITATION



National Employ the Handicapped Week, 1982

By the President of the United States of America

A Proclamation

People throughout our country are working to increase education, training, employment, accessible housing, and recreational opportunities for our disabled citizens.

Of these objectives, employment is one of the most important. To lead more successful lives, disabled Americans must be part of the work force. Progress has been made; many more employers are hiring these quality workers. These employers are part of the growing number who realize they are not "giving" someone a job, but increasing the value of their company or business by hiring a dedicated, skilled employee.

Despite these advances, employment of disabled men and women lags behind that of the general working-age population. There is an urgent need for the private sector to take the lead in offering jobs that provide individual dignity and enable disabled men and women to support their families. There is also a need for state and local governments to employ fresh approaches and renewed energy in cooperation with the private sector to expand handicapped employment opportunities, and for the Federal government to streamline regulations in order to afford maximum benefit for handicapped persons with a minimum of administrative burden.

We need to affirm the dignity and worth of all people in our society, whether or not they suffer from physical or mental disabilities, and we must firmly reject attitudes that deny the worth of handicapped individuals.

Congress has called for the designation of the first full week in October each year as National Employ the Handicapped Week (36 U.S.C. 155). This special week is a time for all Americans to renew our dedication to meeting the goal of increased opportunities for disabled citizens.

NOW, THEREFORE, I, RONALD REAGAN, President of the United States of America, do hereby designate the week beginning October 3, 1982, as National Employ the Handicapped Week.

I urge all governors, mayors, other public officials, leaders in business and labor, and private citizens to help meet the challenge of the future by ensuring that disabled people have the opportunity to participate fully in the economic life of the Nation.

IN WITNESS WHEREOF, I have hereunto set my hand this 13th. day of Sept., in the year of our Lord nineteen hundred and eighty-two, and of the Independence of the United States of America the two hundred and seventh.

Ronald Reagan

I CAN DO IT



Need a job; want security; home; the American Dream? It can be done. Say it. And then do it. Contact your vocational rehabilitation agency (see the yellow pages for address).

Rehabilitation Services Administration

AMERICAN REHABILITATION

Volume 8, Number 1 The weakest ink is better than the strongest memory. *Sept - Oct 1982*

4	Education Via Satellite	Dave Molinaro
10	State-of-Art: Infant Services	Thomas Brubeck
12	New Facility In District of Columbia	
14	Association Aims To Integrate Disabled	Sarah Poon Shui-fong
20	Patient Education For Cord Injured	June B. Mullins, Ph.D., and Judith G. Bendel
26	Classlifying VR Program/System Indicators	Sita Misra, Ph.D., M.S. Tseng, Ed.D., and Ranjit K. Majumder, Ph.D.

DEPARTMENTS

2	Topic of State	16	Notes On The Margin
9	Language Used	24	New Publications
13, 18, 32	News, Notes, Announcements	31	Report Resources

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REHABILITATION SERVICES ADMINISTRATION
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S.W., Washington, D.C. 20201.

Paid subscriptions are accepted (see Cover IV for blank). Correspondence concerning paid subscriptions should be sent to Superintendent of Documents, P.O. Box 1533, Washington, D.C. 20402.

TOPIC OF STATE

New Equipment Requirements

Rehab, in cooperation with the Department of General Services, has produced a uniform set of requirements to be applied to purchases of adaptive equipment for drivers with disabilities. The requirements were drawn up in response to a need to set some criteria for such equipment that would assure the safety and serviceability of adaptive driving equipment. Input on the regulations was solicited and received from equipment vendors and from various driving evaluation program staff throughout the state.

The requirements have been printed under the title Requirements for Adaptive Equipment Purchased for Handicapped Drivers. Any driving equipment purchased by the state after March 1, 1982 must meet these requirements. Copies have been sent to all District Administrators, and a limited supply is available through Rehab's Rehabilitation Engineering Section for those who may need them. Rehabilitation Engineering's number is (916) 322-0715 (voice or TDD).

Rehab Review, California Department of Rehabilitation.

Wheelchair Sports Medicine Network

A wheelchair sports medicine task force has been established to identify individuals involved in the testing, training or treatment of wheelchair athletes.

The task force is especially inter-

ested in physical and health educators, recreation therapists, physical therapists, occupational therapists, nurses, researchers, physicians, exercise physiologists, coaches, athletic trainers, and athletes.

It is planned that this group of interested individuals will exchange their ideas and expertise in the development of research and education projects in wheelchair athletics. Areas of interest include physiological measurement of athletic performance, validation of wheelchair athletic training techniques, documentation of health benefits of wheelchair athletic participation, and athletic injury prevention and treatment.

If you are interested in sharing information, developing resources and establishing a national network, please send name, mailing address, phone number, and a brief description of areas of interest and expertise to: Kathy Curtis, RPT, Wheelchair Sports Medicine Task Force, 4056 Bismark Dr., San Jose, CA. 95130.

The NYS OVR Sun, New York Office of Vocational Rehabilitation.

One In Ten Ohioans Are Disabled New Study Shows

Although results are not yet available from Project OHIOANS, an RSC telephone survey of households with disabled members, preliminary data indicate that nearly 10 percent of all Ohioans have some kind of disabling condition or functional limitation. Additionally, it appears that the southern half of the state has a higher incidence of disability than the northern half.

Information from Ohioans Handicapped Incidence Occurrence and Needs Study, completed in late 1981, is presently being compiled utilizing the

list processing technology of RSC's word processing center for data entry, storage and transmittal.

RSC expects Project OHIOANS to be a very functional and beneficial research project with great utility for the agency's planning purposes, as well as for other agencies and organizations interested in Ohio's disabled population.

A sample frame specific to individual counties was designed for Project OHIOANS by Dr. John Hinton, professor of mathematics, Columbus Technical Institute. A telephone list assembling the specified quantity of telephone numbers by county with proportional distribution by alphabetic sort was acquired from Donnelley Marketing, Chicago. Interviewers were given two days of special training in getting as much detail as possible from the person called in order to achieve accurate, descriptive accounts of the numbers and types of disabling conditions.

Calls were made during two daytime periods and two evening periods, to get a broad spectrum of representation. Generally, daytime calls found the highest concentration of elderly and disabled persons. Interviewers managed to complete the survey with 90 percent of all households after the initial contact was achieved. Initial key questions, which established that a household or family member had a disabling condition, served to update previously erroneous and often misleading statistics.

Project OHIOANS used an expanded definition regarding disabilities, since rehabilitation vernacular has evolved to generally incorporate "functional limitations" within the context of disabling health conditions. "Functional limitations" may go beyond "disabling conditions" specifically affecting employability, and into more general health categories which may impact other aspects of daily living.

The reason for broadening the definition was not to generate higher numbers of disabled people, but to include those with functional limitations and thus give better representation to disabled persons in all age groups.

Final statistics from Project OHIOANS are expected to provide new and better information about Ohioans with disabilities.

—*RSC News, Views*, Ohio Rehabilitation Services Commission.

Voice In Wilderness Reverberates Soundly

Thanks to the quiet persistence of a young woman from Santa Cruz County, the Grand Canyon National Park will soon be more accessible to people with disabilities. Eileen Szychowski, a program manager for the Skills Center, a rehabilitation facility in Capitola, went to the Grand Canyon on vacation, only to find that she was prevented from enjoying all its features because of her orthopedic disability.

First, she found that the trams that ferry visitors around the park were inaccessible. Then a reading of the rules governing the donkey rides through the canyon prohibited their use by a person with a disability.

As a person who is an accomplished equestrian, Eileen found this latter restriction particularly unfair. She had been a prize student in a special riding program in Aptos called "The Dragon Slayers," and was more qualified than most to ride.

It was somewhat ironic to find this particular park to have inaccessible features, since it was discovered and explored by a disabled civil war veteran, John Wesley Power. It was Power, a man with an orthopedic disability,

who was the first person ever to ride the length of the Colorado River through the canyon.

Ms. Szychowski started her campaign by talking to people involved in running the park, from park service employees to private concessionaires. She was pleased to find that they were in agreement with her contention that the park's facilities should be available for everyone to enjoy. They had considered the issue before, but were uncertain as to how accessibility could be achieved.

Ms. Szychowski was invited to participate in a training seminar in October in the Grand Canyon National Park, where she gave a unit on handicapped awareness, Section 504, and related topics. The park also ordered new accessible trams which will be available next July and modified their rules on the donkey rides to allow participation by people with disabilities who can demonstrate their ability to guide and ride the animals safely.

So, through one individual's quiet perseverance, the natural beauty of the Grand Canyon can be fully enjoyed by everyone.

(California's *Rehab Review* thanks Robert Stoll, Program Supervisor in Salinas District, who interviewed Ms. Szychowski and submitted her story for publication.)

Utica Office Picks Boss Of The Year

Emile Truchon, Manager of the Utica Area Office, was chosen second runnerup in a Boss of the Year contest conducted earlier this year and sponsored by local newspapers in the Utica area.

In a letter to the newspapers nominating their boss, 40 employees wrote

that Emile Truchon "has always been available to his staff and constantly urges them to develop their individual and creative talents in approaching their jobs."

The Utica staff has one of the highest percentages of handicapped professionals for this agency in the state. For Mr. Truchon, his most valuable resource has always been the people who work for him, and the emphasis is always on what you can accomplish as an individual.

—*OVR Sun*, New York Office of Vocational Rehabilitation.

Affirmative Action Explained In Packet

Rehab's Affirmative Action Section has put together a comprehensive affirmative action program to help anyone competing in supervisory or managerial exams and to increase everyone's understanding of affirmative action policies and procedures. A packet compiled by Debbie Dunn has been put together to clarify the department's responsibility, policy and accomplishments in this area, as well as giving specifics on legal mandates at all levels.

Copies of the affirmative action program information have been distributed to all middle and upper management staff. Anyone who did not receive the packet can get a copy by requesting it from the Affirmative Action Section. Also, Affirmative Action Chief Anthony Contreras is available to review the information with anyone who would like to have a more complete explanation of its contents. The Section can be contacted by mail (Room 132, 830 K Street), or by telephoning (916) 322-3700 (ATSS 492-3700), Voice or TDD.

—*Rehab Review*, California Department of Rehabilitation.

Education Via Satellite

Dave Molinaro

"The satellite training should be considered a success."—**Bob Montgomery**, Virginia Department of Rehabilitation Services.

Bob's statement echoes the comments of rehabilitation professionals throughout the country who participated in the inauguration of training via satellite for rehabilitation professionals. One year in development, the Rehabilitation Services Network (RSN), a program of the West Virginia Research and Training Center (WVRTC), established a humble but effective rehabilitation beachhead in satellite technology—an information media that will become dominant in the mid-to-late 80s.

On February 9, 1982, 107 rehabilitation professionals gathered at 15 sites across the country to study the ever popular *Vocational Behavior and Independent Living Checklists*. On March 23, 1982, 450 gathered at 37 sites throughout the nation to study *Service Centered Employer Development* and experience the *Employer Maze*. Over 96 percent of these participants said they would attend another RSN telecast. The same number would recommend future RSN telecasts to associates within the human service sector.

RSN is a satellite-based information and training network that blends the

rapidly expanding information needs of rehabilitation professionals with the better side of broadcast studios, satellites, excellent instruction, and authoritative instructors. Simply, it aims conveniently and economically to bring the latest information close to home at a reasonable price.

Five components make up RSN: satellite technology; state contacts/site facilitators; programing; WVRTC; and financing.

Satellite Technology

From one broadcast site (uplink), RSN sends a video and audio signal up to a communication satellite some 22,300 miles above the earth—the signal is there amplified and sent back (splashed) across the entire United States . . . where receive sites (downlinks) capture the signal and pipe it into training rooms that contain television sets and telephones. The receive sites (downlinks) are local public broadcast stations (PBS) where trainees gather for the RSN experience.

State Contact and Site Facilitators

These people, part of the RSN system, provide several critical services. Each state that joins RSN does so through either of these two roles.

The state contact assists WVRTC in identifying competent and personable

site facilitators; in promoting attendance at RSN telecasts; and advises WVRTC in RSN's growth. They are the network's gateway to target audiences in each state.

Site Facilitators handle the off air activities at each training site. They lend that personal touch to the telecast from registration on through to a closing evaluation. Participants also contribute to RSN by identifying professional information and skill-building needs that will serve as content for future telecasts.

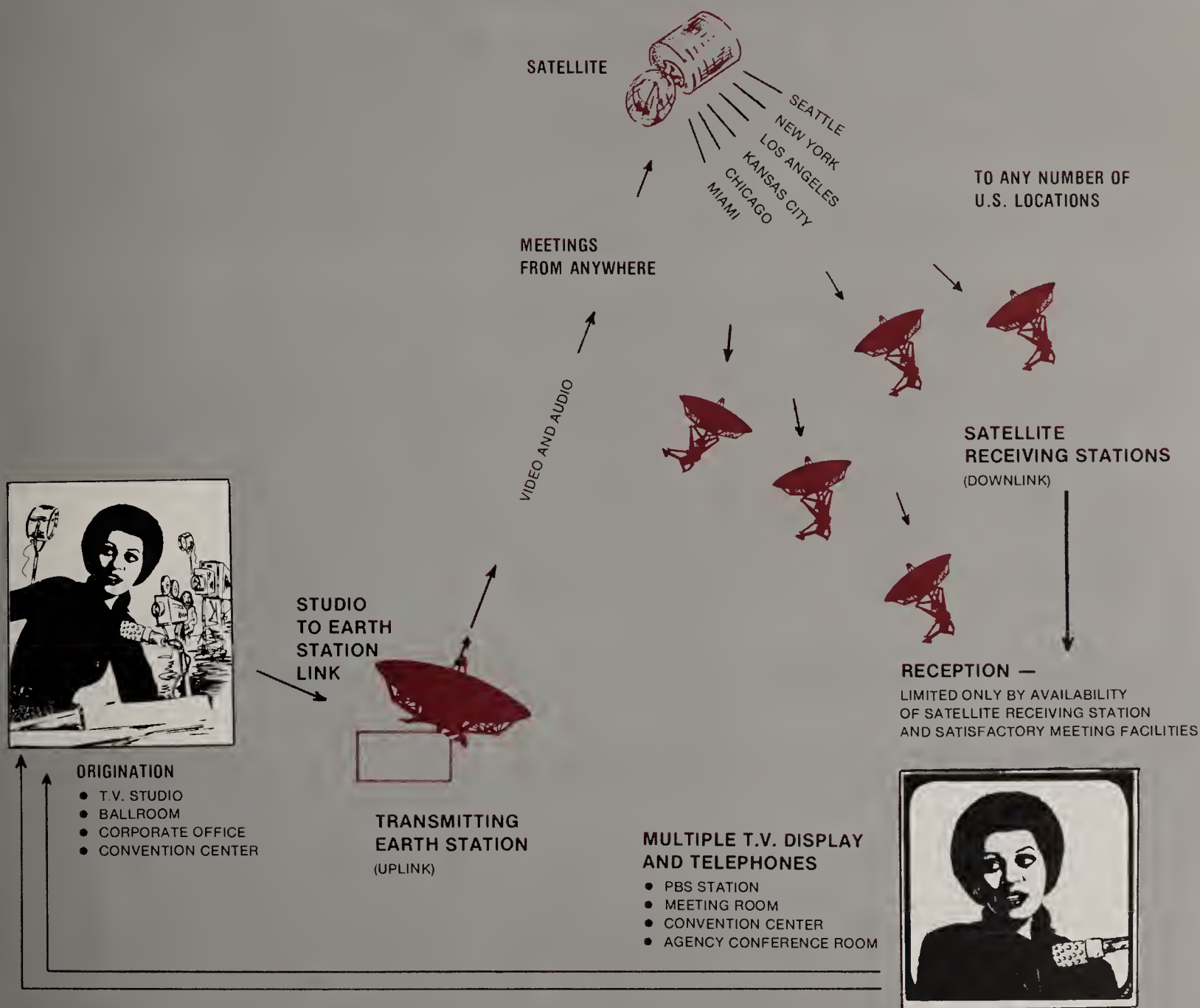
Programing

Each telecast is an "integrated" learning package that consists of carefully designed video portions, complimentary onsite learning activities, a newsbreak, printed materials (such as manuals), a live interactive question and answer session, Certified Rehabilitation Counseling (CRC) credits, and a program evaluation and needs analysis.

Content comes from and/or is presented by nationally accepted experts in their areas. For a typical agenda, see the box material.

Content selections are a result of participant recommendations, state Contact and Facilitator input, and two steering committees. Although the initial programs are by WVRTC

SATELLITE TELECONFERENCING



AUDIO RETURN BY TELEPHONE LAND LINES FOR QUESTION AND ANSWER INTERACTION

REHABILITATION SERVICES NETWORK

staff—future content will come from experts across the country.

During the newsbreak, an important rehabilitation personality updates participants with late breaking news regarding legislation, budgets, and programs.

Those questions not answered on the air are answered later. Site facilitators send in such questions and WVRTC staff answer each in writing after the telecast.

Each participant may apply for CRC and/or Continuing Education Unit (CEU) credits to maintain professional status.

WVRTC

The Center coordinates network components and produces each learning experience.

Financing

The network exists on tuition revenue. A typical telecast costs several thousand dollars. By spreading the cost over many participants, the network can sustain itself and generate revenue to telecast future programs. Tuition fee for the first two programs was \$45 per person. The most expensive item in the network is receive site rental (PBS stations). Sites account for more than 50 percent of the telecast cost. Through state contacts and other interested parties, RSN is seeking to identify less expensive receive sites. Plans are in effect to explore each state purchasing its own receive dishes.

The five components just reviewed are being fine tuned, based on the feedback or evaluation of network participants (contacts, facilitators, trainees, advisors). The evaluation is two staged—immediate “onsite” and “remote.”

Onsite: Overall the results were positive in the first stage of evaluation conducted onsite immediately after the telecast.

RSN AGENDA SERVICE CENTERED EMPLOYER DEVELOPMENT

EST	CST	
9:30 - 10:00	8:30 - 9:00	REGISTER
10:00 - 10:35	9:00 - 9:35	WELCOME AGENDA AND PROCEDURES INITIAL LEARNING ACTIVITIES
10:35 - 11:44	9:35 - 10:44	INSTRUCTIONAL TELECAST: SERVICE CENTERED EMPLOYER DEVELOPMENT
11:44 - 11:50	10:44 - 10:50	NEWSBREAK: DAVE MILLS OF NRA
11:50 - 12:13	10:50 - 11:13	QUESTION AND ANSWER—LIVE, NATIONWIDE
12:13 - 12:15	11:13 - 11:15	PREVIEWS AND TELECAST CLOSE
12:15 - 12:45	11:15 - 11:45	LUNCH
12:45 - 2:00	11:45 - 1:00	THE EMPLOYER MAZE
2:00 - 2:30	1:00 - 1:30	EVALUATION AND NEEDS ANALYSIS CRC AND CEU CREDIT INFORMATION

Critical comments on the February 9 program concerned some audio distortion during the live question and answer period.

On March 23, the worst possible event happened—the system crashed before air time. This delayed the program one hour while new satellite time was purchased. Were it not for RSN facilitators on site, the program would have surely collapsed. Facilitators filled in with some creative activities like discussions on the effect of delays

on clients; tours of the broadcast facilities, and several placement-related exercises.

The evaluations captured dissatisfaction with the the delay . . . but, in both instances of technological problems, most participants recognized such problems as solvable.

Remote: A second phase of evaluation has involved an “application” report by trainees 3 to 4 months after the telecast. In this evaluation, respondents described how and to what

extent the learned skills, tools, and concepts have been applied in their daily performance.

This two-staged evaluation and the satellite experience of other professions (American Dietetic Association, American Law Institute) have suggested the following RSN benefits . . . economy, convenience, availability, and excellence.

- Satellite transmission can reduce both staff travel expenses and costly time away from the job by bringing programs nearer to staff.

- This technology can deliver today's rather expensive content and instructional specialists more economically. Recently, a rehabilitation manager observed that "transporting information in human containers is extremely expensive."

- Network offerings are intended to compliment, not replace, an organization's current effort to meet the growing informational needs of its staff. For some organizations, therefore, the network will offer an economical way of expanding and enhancing the variety of already existing programs.

Convenience

- The programs come to each organization already complete and carefully designed. Development and maintenance costs are drastically reduced. Internal staff development personnel are more available to focus on special organizational demands.

- User convenience exists as each program is offered near the work site, thus reducing time away from employment and home. Gradually, programs will come directly to field offices.

- Participants can count on a regular menu of CRC and CEU credits.

Availability

- The network can present fast breaking, fresh topics of concern to rehabilitation professionals; e.g., pend-

Even now, surely later, both information availability and its effective use will separate professional success from failure, excellence from mediocrity.

ing legislation, in timely manner.

- Since RSN broadcasts originate from Washington, D.C., policymakers, legislators, and other significant resources are accessible for live appearances—newsbreaks at each session.

- Rehabilitation professionals will have access to generally unavailable content and presenters. Most excellent content presenters do not have the time to visit each state, nor the resources to develop media materials.

- Should an organization require it, content can be delivered to all staff simultaneously at multiple sites across each state, across the nation . . . thus enhancing the material's impact.

- Critical, new topics can both reach a wider audience and penetrate deeper into an organization structure.

Excellence

- Because costs are shared on a wide basis and RSN will draw upon a national talent bank, the network will bring the best and most authoritative (usually very expensive) presenters to its audience.

- Keeping cost containment and efficiency in mind, each program is tightly designed to maximize the use of trainee time.

- Because all participants receive the presentation simultaneously—no middle person—the information is accurate. For example, Virginia had 5 sites with 111 participants. Florida had 3 sites with 30 participants. Pennsylvania had 2 sites with 43 participants, and New York had 2 sites with 34 participants.

Were all these benefits realized during the original broadcast? No! For example, although the March 23 program was available at 37 sites in 25 states—for a vast number of people, these sites were not convenient. Travel costs would have been too high.

The solution is the development of multiple receive sites per state—each carefully located to be accessible to a broader number of professionals. Remember, the signal splashes down across the entire country—your roof is getting hit by such signals as you read—what's lacking is a receive dish (antenna) to grab the signal. Therefore, as receive-dish prices decline—RSN will encourage organizations to purchase their own dishes. Prices now range from \$5,000 to \$15,000. Given the growing number of telecommunication satellites, channel selection is currently in the 300 range. With the number of broadcast groups increasing—lawyers, doctors, dentists, and colleges and universities, the use of such dishes for professional development goes far beyond RSN telecasts.

Sites are again restricted by the high rental fees mentioned earlier. If a site does not draw enough paying participants, RSN cannot afford to carry the site and it is dropped. The breakeven number may, for example, be 22. If only 15 people register, the site is cancelled—and 15 people do not receive desired information.

The solution, in part again, is local state organizations negotiating lower rental costs or buying their own receive dishes.

What does the future hold? RSN will begin its 2nd season early in 1983 and telecast five programs. Topics currently under consideration include disability management and mental health in the workplace, low back functional assessment in rehabilitation, expert witness, marketing, motivation, a sequel to last season's telecast of employer development, and a national handicapped consumer conference.

In preparation for this coming season, RSN will focus on five areas:

1. *Additional sites*—as suggested earlier, RSN will expand into states not currently in the network. RSN is under-represented in the South and far West. Furthermore, current network states will gradually acquire more sites.

2. *Less expensive sites*—either by negotiation with receive sites (PBS stations, hospitals, and hotel chains) reduce current rental prices via "package" or "series" discounts; or reduce such costs through a one-time purchase of receive dishes by participating organizations; or through cooperative efforts with nonrehabilitation organizations, such as the American Law Institute, the U.S. Chamber of Commerce, and the Hospital Network, purchase shared-use dishes.

3. *Cosponsors*—RSN, to meet varied participant needs, will enlist programming content and support from allied organizations such as research and training centers, RCEP's, V.A., National Rehabilitation Association, mental health, special education, rehabilitation facilities, and the private sector.

4. *Varied access*—For its fifth telecast in late spring, RSN will refocus program content from human service professionals to a large audience of handicapped individuals. Using cable systems as downlink facilities, the program will be channeled to both barrier-free viewing sites and directly into consumer homes. The Presidents Com-

mittee on Employment of the Handicapped and the National Rehabilitation Association will cooperate with the West Virginia Research and Training Center to facilitate local audiences and cable system relationships.

5. *Increased programing*—Within 2 years, RSN will move to a monthly telecast schedule and, if enough cosponsors are identified, weekly programing.

To close, in addition to peer dialogue print materials and live learning experiences, the rehabilitation community is adding a vital source to its information and training channels—RSN.

Futurists speak of information as the coin of personal wealth or its lack, personal poverty. Observers are naming tomorrow's professional "information workers." One significant and persuasive "exception" to predicted scarcities in the human service future is information. Even now, surely later, both information availability and its effective use will separate professional success from failure, excellence from mediocrity.

As the rising cost of both travel and time reduces individual participation in training events; as the organizational cost for both personnel skills and knowledge obsolescence increases and, as the growing complexity of professional demands calls for increased input, each professional, to remain so, is seeking alternate ways to both fine tune and increase the fidelity of their personal performance. The Rehabilitation Services Network appears to be part of the solution, part of the way.

If you or your organization wishes to join RSN—be a contact, site facilitator, attend programs, provide content, or buy a dish—drop us a line: Welcome RSN, The West Virginia Research and Training Center, One Dunbar Plaza, Suite E Dunbar, West Virginia 25064.

Dave Molinaro is a training associate with the West Virginia Research and Training Center and Coordinator, Rehabilitation Services Network.

If you find in **American Rehabilitation** the kind of material that informs or that is useful to you in some way, a colleague who does not receive the magazine may also profit by it. If you know such a person, fill out the blank below and send it to Editor, **American Rehabilitation**, Room 3525, 330 C street, S.W., Washington, D.C. 20201. We will be happy to send your friend a sample copy of the magazine.

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Language Used or Used Language?

sics, regardless of economic conditions. Basic management principles are fairly straightforward and grow out of the good and true dictum that has arisen from the practice of common sense. Like common sense, basic management principles are always in vogue and outlast the trendy jargon that rises with each new moon of political or economic happenstance."

Superabundance. Sue these words for nonsupport.

[illegible]

“... site visits to all the agencies. . . .” If you visit, you move from one place to another. *Visit* encompasses at least two “sites,” one that you left and one that you go to. When you have identified where you are going (*i.e.*, in this case, “all the agencies”),

Freely and felicitously, we fancy feline farsightedness. Little wonder, then, our ingratiating at our favorite feline's reply to his master when the master tells Garfield (syndicated cartoon by Jim Davis) that he is going to get Garfield "some professional psychiatric help." Garfield's reply: "You mean there are amateur psychiatrists?"

“The essence of eloquence is that behind the language lies commitment: the words count.” “The Presidency” by Hugh Sidey, *Times*, Dec. 1, 1980.

9

State-of-Art: Infant Services

Thomas Brubeck

The prevention of handicaps can begin at birth, if not before. But the fast-developing field of early childhood services, which is not much older than its clients, has had some growing pains.

The 1960s saw an explosion of knowledge on the importance of getting at problems early in an infant's life. To some behavioral scientists, infants would have the equivalence of a Ph.D. by the time they saw the inside of a kindergarten.

Then along came others who challenged the notion that the impact of early negative experiences need be lifelong. Their philosophy was that life could begin at 5 years—or whatever. Work with what you have at any point.

However, people who deal with ideas often go into overkill, and the reaction to early educators escalated. The attack was extended into questioning the positive effects of an enriched environment in the early life of a child.

The truth is being sought somewhere between the north and south poles. One aspect of a state-of-the-art project on early childhood services carried out by the Frank Porter Graham Child Development Center, University of North Carolina, stated: "The basic argument of whether to intervene early in life or later is not an either/or position."

This study mentions handicaps as examples of why time and duration of intervention is no simple matter. Nicholas Anastasiow pointed out that early intervention can markedly change the

outcome of the handicapping condition if it occurs during the first 2 years of a child's life. He said that if intervention is not introduced until the age of 6, much can be done to improve the effect of impairment, "but rarely has later intervention had the same impact as early intervention."

Anastasiow, with evidence drawn from recent neurological research with animals, said that environmental stimulation should begin before the brain systems mature.

Anne M. Hocutt, on *The Effectiveness and Impact of Early Intervention Services for Developmentally Disabled Children*, also has some strong feelings on the subject. She said, "It has been shown that developmental competencies in handicapped children can indeed benefit from intervention. Further, there is some evidence that approximately one fourth of the variance in the rate of developmental progress for a handicapped child is accounted for by psychosocial factors, not organic factors."

Hocutt pointed out that research has shown that handicapped children who have received early intervention and infant stimulation are more likely to be placed in advanced educational settings and that the differences between children served and those unserved have tended to increase over the years, not "wash out" as has been the case for some at-risk children.

The variables are always with us, preventing these matters from being

neat and easy, and researchers pointed out that the extent to which disabled children can benefit from early intervention depends on many things: age at entry into a project, length of services, severity and types of disabilities, degree of structure, focus of program (communications, social-adaptive behavior, etc.), program setting, precision of instruction, and parent involvement.

In some cases, disabled children are slower learners than the nondisabled, but the sequence of "developmental milestones" is the same, according to Dordelia Robinson and Steven Rosenberg, who wrote a chapter, "The State of Knowledge About Developmentally Disabled Children."

Studies show that disabled children not only learn the same concepts in the same order as normal children, but also that they need to accomplish the same developmental tasks of communication, mobility, problem solving, and daily living skills. It is this concept which forms the developmental model of services for young handicapped children.

Robinson and Rosenberg bring out that an environment favorable for development of a normal child "is the minimum necessary for the development of a handicapped child." They also state that the first few years are not the only opportunities for improving development. They urge continued intervention, reminding that preschool intervention is not an "innoculation"

against further adverse experiences.

From examination of 190 programs, Marie Bristol and Joan Bartel wrote a paper on exemplary, comprehensive programs for young disabled children.

While they are not locked-in on any operating methods, they pointed out those dealing with the integration of services. They pointed out certain things that successful programs have in common. They described an "ideal" program (their quote marks) as having these features:

- *Child find*: A coordinated mechanism for identifying potential clients, assessing needs, and locating services.

- *Multi-disciplinary diagnosis and assessment*: A coordinated evaluation by a team of specialists from a variety of fields who assess the child's status and function in all major developmental areas.

- *Individual treatment or habilitation plan*: A plan written with parental consent and help which usually specifies strengths and weaknesses of the child, present level of functioning, long and short-range program objectives, and provides for periodic re-evaluation and revision.

- *Comprehensive services*: A full range of programmatic services designed to meet the client's needs provided through coordination or integration of services among multiple service providers.

- *Consumer involvement*: Opportunities for involvement of parents of all phases of operation, including design and evaluation of programs.

- *Follow-along*: A formal mechanism to insure that the child actually receives needed additional services provided outside the scope of an individual program.

- *Evidence of program effectiveness*: Systematic evidence in addition to monitoring the individual child which shows the overall program is effective for groups of children.

- *Staff training*: Evidence that program staff have training and experience to meet client needs and that training is on a continuing basis.

- *Theoretical adequacy and consistency*: Evidence that the treatment program represents a consistent programmatic approach based on the best available knowledge regarding prevention, amelioration, and rehabilitation.

- *Case management system*: The assignment of a specific person responsible for assuring, documenting, and evaluating continuity of care during all phases of treatment within an agency and across agencies.

The researchers include vignettes of five programs as examples of comprehensive delivery systems: Family Head Start Program in Oregon is representative of a collaborative effort; the Kona Child Development program in Hawaii illustrates collaborative funding; the Mailman Center program in Florida describes linkages possible

through University Affiliated programs; the Regional Program in New Hampshire represents a regional program; and the Preschool Program of the Southeast Mental Health and Retardation Center, serving 3,600 square miles in North Dakota, was originally funded as a Community Mental Health Center and evolved into a Human Resource Center.

While this sizable addition to the literature concentrates on infants, in many respects it covers methods of operations for handicapped people of any age.

("State of the Art Project in Child Development Services," Frank Porter Graham, Child Development Center, University of North Carolina, 300 NCNB Plaza, 322H Chapel Hill, NC, 27514, \$25.)

Mr. Brubeck, a frequent contributor to *AR*, is an information officer for the Department of Health and Human Services.

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New Facility In The District of Columbia

Washington, D.C.—Plans to build the city's first hospital devoted exclusively to rehabilitation have been approved by all local and federal agencies and construction of the 240-bed facility will begin on the site of the old Children's Hospital in Northwest Washington, D.C. this summer. The \$45 million facility is scheduled to open in mid-1984.

Edward A. Eckenhoff, a nationally prominent administrator in the rehabilitation field, has been appointed President and Chief Executive Officer of the National Rehabilitation Hospital (NRH). Thomas Breitenbach, formerly of Miami Valley Hospital In Dayton, Ohio, has been named Senior Vice President and Administrator.

Eckenhoff comes to Washington from the prestigious Rehabilitation Institute of Chicago, a 170-bed affiliate hospital of the McGaw Medical Center of Northwestern University and prototype for the larger Washington facility. There, he served as a Director and its Vice President and Administrator since 1976 and Administrator since 1974.

Eckenhoff, himself a paraplegic since an automobile accident in 1963, has been a forceful advocate of the needs and rights of disabled citizens. He has actively worked to improve reimbursement of rehabilitation expenses by insurance and third party payers and has been vocal in his attempts to improve social attitudes toward the physically disabled.

Among his many appointments,

Eckenhoff serves on the Board of Directors of the National Association of Rehabilitation Facilities, the Governing Council of the Chronic Disease and Rehabilitation Section of the American Hospital Association, and the Board of Directors and as an administrative survey consultant for the Commission on Accreditation of Rehabilitation Facilities.

He also has served on the medical school faculty of Northwestern University and as a preceptor for Northwestern's health care administration program in the Graduate School of Business. He holds several master's degrees, one of which is in health care administration from the Washington University School of Medicine, St. Louis, Missouri.

An author of numerous articles on rehabilitation, Eckenhoff was appointed by Illinois Governor James R. Thompson to serve as statewide Chairman of the Governor's Committee for the International Year of Disabled Persons. He also has served on the Board of Directors of the Chicago Health Systems Agency.

Thomas Breitenbach joins NRH from the 750-bed Miami Valley Hospital, one of the largest comprehensive medical centers in the Midwest. There he served as Chief Financial Officer and Senior Vice President of Affiliated Institutions since 1979 and was responsible for the management of two hospitals and two extended care facilities. Previously, he served as Director of Finance at the Rehabilitation Insti-

tute of Chicago from 1976 and was with the hospital management firm Hospital Affiliates, Inc., Nashville, Tennessee, from 1975 to 1976.

He holds a Master's in Business Administration from Xavier University, attended the Professional Accounting Program at Northwestern University's Graduate School of Management and the Ph.D. program in Business Administration at the University of Chicago. Breitenbach is a Certified Public Account and worked for the accounting firm Arthur Young & Company from 1973 to 1975.

NRH was awarded a Certificate of Need last October from the D.C. State Health Planning and Development Agency to open 160 beds initially and the remaining 80 when the original bed complement sustains 85 percent occupancy. In addition, the U.S. Department of Housing and Urban Development has granted preliminary approval on a \$40 million mortgage insurance application to the hospital's developers, banker, and real estate investor Jeffrey N. Cohen, Washington attorney Samuel C. Jackson, and architect Theodore Mariani. NRH also has received commitment from Suburban Mortgage to finance the construction and permanent loan.

Architectural plans for the new hospital include construction of a four-level, 264,000 square foot building and renovation of 116,000 square feet of existing structures on the 2.4 acre site at 13th and V Streets, NW. An atrium will create a bright, open atmosphere

psychologically conducive to rehabilitation. The hospital will help revitalize the Shaw community replacing decayed buildings that have stood vacant over 5 years and will create several hundred jobs.

NRH will fill a long felt need in the metropolitan Washington area for comprehensive rehabilitative care. Several area hospitals provide some rehabilitation services primarily for the acute early phases of injury or illness. But there are few facilities to provide treatment for virtually millions of Americans who are disabled every year.

Free-standing specialty hospitals

such as NRH supplement the efforts of acute care facilities by striving to assist the disabled in reaching their highest level of independent functioning as well as returning them to their communities and the work force. Physicians and rehabilitation nurses, physical, occupational, speech and recreation therapists, vocational counselors, psychologists, social workers, rehabilitation engineers and others employ an intensive team approach to assist patients in returning to productive lives.

NRH will provide services for patients with spinal cord injuries, cerebral trauma, neurological disorders, orthopedic problems or amputations,

chronic pain, arthritis, stroke and other disabling illnesses and injuries. Extensive outpatient services and a day treatment program also are planned.

Rehabilitation, says Eckenhoff, can help return people to productive employment. "The average patient who has been rehabilitated and returns to community, home, and work contributes to the economy and no longer requires government or private benefits or subsidies. It makes great ethical and economical sense to provide effective, comprehensive medical rehabilitation programs for those who may require them," he added.

NEWS, NOTES, ANNOUNCEMENTS

"Dignity" Sculpture Finds New Home

"Dignity," a sculpture commissioned for the International Year of Disabled Persons (IYDP) and on display at the United Nations until July 1982 will have a permanent home at The Burke Rehabilitation Center in White Plains, New York. The 4-foot, 300-pound sculpture commemorating the IYDP is by Black American sculptor Alvin Paige, who is Artist-in-Residence at the American International College in Springfield, Massachusetts.

Paige and representatives of the American Cultural Arts Council, the U.S. IYDP Committee, government, and the arts were present when the work was unveiled and dedicated at Burke, Wednesday, July 21. The work will be displayed in Burke's Wood Lobby until the Spring of 1983, when it will be moved to a permanent position on the hospital grounds.

Crafted of oxidized, polished, and brass-cladded steel, the sculpture de-

picts a person in a wheelchair breaking out of a two-dimensional disc on which is represented Leonardo da Vinci's symbol of man. The dramatic contrast of the static depiction of the physically ideal man with the energy and dynamism of the three-dimensional, disabled person conveys both the individual and social dimensions of the IYDP as well as the growing momentum of efforts to gain acceptance and opportunity for disabled persons. The IYDP, observed in 1981, mobilized communities worldwide to work for the "full and equal participation" of disabled persons in their communities.

The title of the work comes from a quote by Dag Hammarskjöld: "The only kind of dignity which is genuine is that which is not diminished by the indifference of others."

According to Paige, Burke was selected because of its prominence in medical rehabilitation as well as the beauty of its grounds. Founded in 1915 as a convalescent center, Burke is now a private, not-for-profit rehabilitation hospital affiliated with the New

York Hospital-Cornell University Medical Community. It is located on a 65-acre semi-wooded campus in White Plains.

Paige is best known for his large sculptures, which have been displayed throughout the United States, as well as in Korea and Rome.

Mental Problems In Youth Put Burden On Health Facilities

Marguerite Michaels-Daystar

The increasing number of young adults with chronic mental problems is creating serious problems for mental health services, according to psychiatrists from three states. "Growing numbers are vagrant street people," said Dr. Leona Bachrach, associate professor of psychiatry at the University of Maryland Medical School. These street people, however, are not like the typical alcoholic vagrants of the past. They're "delusionary, unpre-

(Continued on page 18.)

Association Aims To Integrate Disabled

Sarah Poon Shui-fong

Concern for the disabled in society should not fade just because the International Year of the Disabled has passed. The message "integrate the disabled into the community" is that of the Hong Kong Physically Handicapped and Able Bodied Association (Hong Kong PHAB Association).

The association, established in 1972 and closely connected with the British PHAB Association, is an approved charitable institution and is mainly funded by government subventions and public and private donations. Its principal activity is to promote the PHAB message which aims at integrating the physically handicapped with the able bodied in the community of Hong Kong.

Hong Kong is a tiny British-administered territory at the southern edge of China, with a population of 5.2 million, of which around 440,000 are physically or mentally handicapped to some degree.

The association started out with a small group of enthusiasts who realised the importance of this concept which works to the benefit of the handicapped and society as a whole. After 2 years' effort, they succeeded in getting the government's recognition and established, with financial assistance from the government, the first PHAB centre, at Sham Shui Po on the Kowloon Peninsula. Now there are four activity centres established as regional centres to serve different parts of Hong Kong Island and Kowloon.

The Chai Wan PHAB Centre serves the eastern part of Hong Kong Island, and it was established in 1976. Two years later, the Lam Tin Centre was opened in Eastern Kowloon, and, in 1979, the largest and most fully equipped centre was built at Pokfulam on the western part of Hong Kong Island. The Lady MacLehose Pokfulam PHAB Centre houses the headquarters of the Hong Kong PHAB

Association is the never centre of all activities organised by the association.

There are 14 PHAB clubs in operation at the four centres with 2,903 members. The number of events organised in 1981 at these centres was 86 with 6,305 participants. Centre-based activities include interest groups, evening classes, friendship groups, and volunteer groups.

Apart from these, the association cooperates closely with other organisations with a common objective, such as the Urban Council of Hong Kong and the Recreation and Sport Service. For example, members participated actively in the "Walk for the Disabled" organised by the Hong Kong Community Chest last year.

"It is our purpose to organise programmes and activities for both the handicapped and the able bodied. We try to provide chances for them to get together and understand each other. If handicapped people are to integrate into the community, it is necessary for the public to accept and encourage them" said one of the officers of the association, Mr. Chu Hung-cheung.

Of the four centres, the Lady MacLehose Pokfulam Centre has always played an important role. Besides being the headquarters, its serene and comfortable setting, its special design for the physically handicapped, its accessibility and its ever-expanding facilities make it more and more popular.

There has been a remarkable increase in the number of campers using



the Pokfulam Centre—from 24,601 in 1980, to 34,860 in 1981.

Apart from a hostel, which can accommodate 100 people in 25 rooms at a time, there are also a basketball court, an activity hall, an audio-visual room, a rest room, canteen, archery range, and a swimming pool.

“Everything is designed for the physically handicapped—the bath-rooms, staircases, and corridors—though many able bodied people like to use our facilities as well.

“The centre is always fully booked, especially at weekends and on Sundays when many other voluntary organisations arrange activities for their members,” said Mr. Chu.

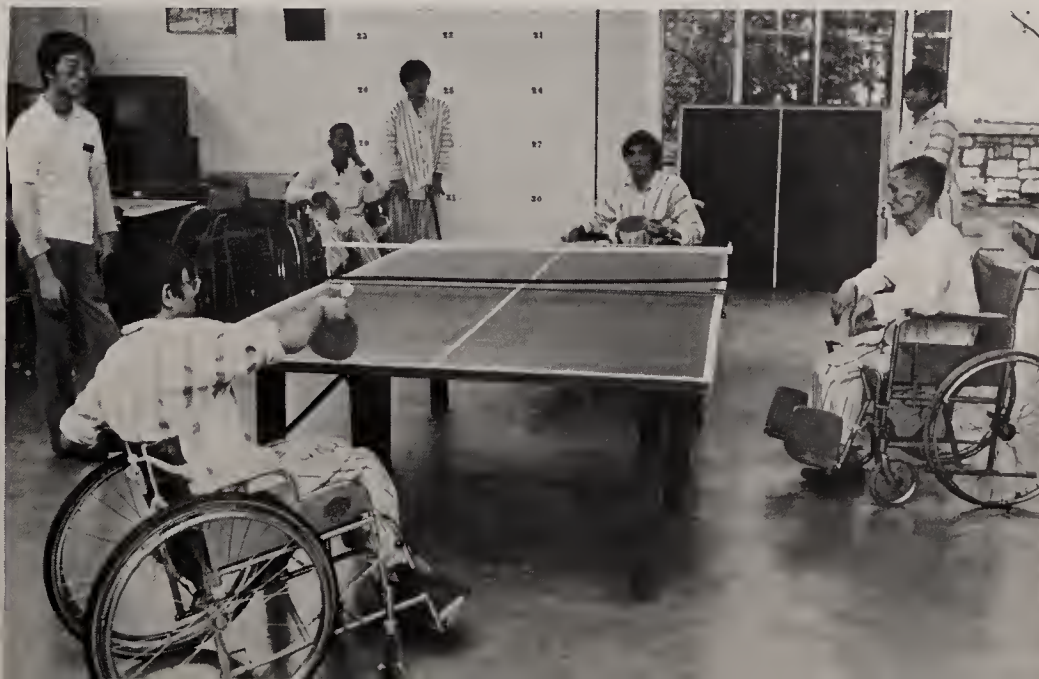
In years to come, the association plans to expand the scope of its programmes to cover all kinds of educational, vocational, and community service training activities. Special emphasis will be given to musical and other cultural activities, such as the organisation of a PHAB choir, a Chinese music group, a drama group, and a brass band.

“However,” said Mr. Chu, “There are many problems we have to solve. The question of staff is one. At the present, we only have 39 staff in total, of which 6 are college graduates and are professionally trained in social work services. They have to carry out administration and organise activities with the help of 10 assistants who have no professional training in college. We try to provide as much inservice training for them as possible and encourage them to take relevant extramural courses offered by the two universities in Hong Kong.

“The most pressing difficulties are how to encourage physically handicapped people to get out of their “sanctuaries” and join in community activities, and how to change the public’s attitudes toward these people,” said Mr. Chu.



The Physically Handicapped and Able Bodied Association of Hong Kong lives up to its name and its philosophy that “awareness” is the key factor in breaking social stigma. The photo on page 14 shows both able-bodies and handicapped people readying for an athletic competition. Photo above shows the lovely architecture of the Lady MacLehose Pokfulam Centre where, among many other facilities, the table tennis area is shown (below).



Notes on the margin...

Cross-Country Skiing

The ninth annual Ski for Light International will be held at Telemark Lodge, Cable, Wisconsin, February 27-March 6, 1983. Ski for light international, sponsored by HEALTHsports, Inc. in cooperation with the Sons of Norway and the ULLR Ski Club, is a week long program designed to introduce visually impaired and other physically disabled adults to cross-country skiing.

Visually or mobility impaired adults may request participant applications from Grethe Winter, Screening Coordinator, P. O. Box 2971, Reston, VA 22091. The approximate cost is \$300 for first-timers and \$350 for repeaters. Cost covers room and board (based on double occupancy), equipment, transportation to and from Telemark Lodge from the Minneapolis/St. Paul airport. Stipends are available for first time participants, based on need.

Conference On Tape

Audio cassette tapes recorded during the Second Annual International Conference on Rehabilitation and Independent Living are available to health care professionals. The tapes feature a series of lectures and seminars presented by Daniel Freeman Memorial Hospital. Over 25 topics were chosen for distribution, including "Identification and Management of Chronic Pain," "Is Disability Newsworthy?," "Innovative Fundraising Strategies for the Eighties," and "Sexual Recovery of the Stroke Patient." For further information on the topics and their cost, write to Susan B. Haskell, Daniel Freeman Memorial Hospital, P. O. Box 100, Inglewood, CA 90306-0008 or call (213) 674-7050, extension 3411.

See You At The Fair

People with walking impairments will have access to the World's Fair in Tennessee through a variety of mobility aids offered for rent on site by a concessionaire. The three-wheeled, motorized AMIGO wheelchair is one of the popular items offered. It is particularly attractive to users because of its compactness and easy maneuverability.

Self-Defense

A new, 31-minute, color, 3/4 inch video tape cassette shows wheelchair users elements of self-defense. The program is promoted by Louis Reddish, a paraplegic of 12-years, and two veteran police officers. The program costs \$190 and can be ordered from PARA-MEDIA Productions, 2080 Sharon Lane, Memphis, TN 38127.

Workshops Available

Moss Rehabilitation Hospital has announced the 1982-83 Moss Workshop Series, a calendar of training and educational programs for professionals and consumers on areas related to physical disability and rehabilitation. Workshops address such topics as reconstructive surgery for rheumatoid arthritis, recreational services, driver training for the disabled, and recent advances in physical medicine and rehabilitation.

In addition to the scheduled programs, Moss offers mini workshops which are tailored to the specific needs of an organization or business. They can focus on such areas as hiring, awareness training, and architectural accessibility.

For further information and a brochure about these programs, contact Moss workshops Moss Rehabilitation Hospital, 12th Street and Tabor Road, Philadelphia, PA 19141, or call (215) 329-5715, ext. 2116; TTY (215) 329-4342.

Foreign Conferences

The "4th International Conference of European Association for Special Education" will be held in Tel Aviv, July 24-29, 1983 and the "2nd International Symposium on Design for Disabled Persons" will be held November 13-18, 1983, also in Tel Aviv. Details may be obtained from Dr. E. Chigier, KENES, P.O.B. 29784, Tel Aviv 61297, Israel.

NEWS, NOTES, ANNOUNCEMENTS

MENTAL PROBLEMS (Continued from page 13.)

dictable, spaced, burned out," she said. "They are very mobile and often travel from city to city, staying in one place only a short time."

Dr. Bachrach said they use mental health services in a "revolving-door way." They become regulars in the emergency rooms of general hospitals, but they are difficult to engage in treatment. In the past, many would have been hospitalized several times or for a long period of time, she said. But because of deinstitutionalization they spend little if any time in psychiatric institutions. Dr. Bachrach reported their average length of stay in institutions is 14 days. "Few facilities know what to do with these people," she said. "There is no niche in the service system for them."

A large number have a history of alcohol and drug abuse, said Dr. Bert Pepper, Director of community mental health services in Rockland County, N.Y. Dr. Pepper said a study he is doing of 800 young adults and chronic mental patients has revealed that 55% have abused drugs or alcohol. A similar study in California put the figure at 90%. He said that drug use in adolescence precipitated the mental illness of some. "There is accumulating evidence," Dr. Pepper said, "that even the brief use of marijuana may be the precipitator of psychiatric illness with persons who have a predisposition for it." He defined the young adult chronic mental patient as someone between the age of 18 and 35 who shows persistent and severe impairment of psychological and social functioning, and

who needs continuing services of mental health agencies. These patients often make poor use of such services, he said.

Dr. Audrey Worrell, Commissioner of Mental Health in Connecticut, said most of these young adults are not institutionalized, and only about 10% are under treatment at any one time.

The psychiatrists said the young people are difficult patients, often suicidal, very withdrawn, or very disruptive, and sometimes in trouble with the law. "Failure is the most common element in their experience," said Dr. Pepper. They begin school, drop out, get jobs and lose them, get rejected in their personal relationships, and try to separate from their parents, but can't. Even though they make up only 10% of the institutionalized population, they take up 40% of the staff's time.

Dr. Bachrach said about one-third of the nation's population is now in this age bracket, and this is having a "marked impact" on the psychiatric system. Because of deinstitutionalization, these chronic patients are not getting the continued care they need.

The Weekly Pulse, Fergus Falls, Minnesota

Rehab Engineering Center To Tap Communication Tech

A technological revolution is occurring in American society, particularly in the communications industries. How can these rapid advances be exploited for the benefit of hearing impaired people?

The Research Institute's new Rehabilitation Engineering Center for the

Hearing Impaired (REC) is seeking answers to that question. Directed by noted speech scientist James M. Pickett, the center resulted from a \$1.1 million, three-year award from the National Institute for Handicapped Research.

The REC taps "high tech" expertise by working collaboratively with scientists at the Massachusetts Institute of Technology, Johns Hopkins University, and Stanford University. The REC staff will also keep track of emerging technologies and will work to interest other scientists in applying new knowledge to deaf people's needs.

The particular focus of the REC is speech communication. These projects are under way in the first year of the center's operation:

Dr. James M. Pickett is working with Johns Hopkins University and MIT on a wearable multi-channel vibrotactile receiver designed to represent speech sounds on the skin of the hearing impaired person, particularly for those moderately-to-profoundly impaired persons who receive little or no benefit from conventional hearing aids;

Dr. Sally Revoile is working to develop hearing tests to measure an individual's perception of acoustic cues in speech. Her tests will yield specific diagnostic information over the more general information now obtained through speech audiometry and pure tone measures.

Dr. William McFarland and Dr. Pickett are collaborating with scientists at Stanford University to evaluate the long-term speech perception performance of deaf persons who have had cochlear implant surgery, as compared with the results obtainable via auditory, vibrotactile, and other less invasive procedures.

Dr. George Fellendorf is heading up the Technology Monitor/Survey unit of the REC, which is charged by NIHR with becoming the major information resource in the U.S. in the area

of speech communication for hearing impaired people.

Reproduced from *Newsletter*, Spring 1982, Gallaudet Research Institute.

Laser Breakthrough

A new laser beam treatment has been discovered that has the potential of preventing an estimated 13,000 cases of blindness a year in America, by using lasers to seal off the abnormal ocular bleeding that often occurs in cases of senile macular degeneration, the leading cause of blindness in people over 50.

While research on this new laser technique is still in the early stages, the method has proved so effective that research results are being disseminated early to allow doctors to start using it right away. First designed as a five year test, the research project set up to examine the effectiveness of the laser technique showed a 70 percent rate of arresting the disease. In contrast, 60 percent of those in the study who did not receive the treatment lost most of their vision. Because of this high success rate, the project was terminated after three years and its results written up for publication. It is estimated that widespread adoption of this procedure by eye specialists will reduce the incidence of blindness by 14 percent over a year's time.

Kaiser Roll Won By Boston Marathon

The 1981 Boston Marathon winner, Jim Knaub of Long Beach, Calif., was the winner of the ten kilometer race at the first Kaiser Roll held in Bloomington, Minn. Knaub, 26, competed in a wheelchair.

The Kaiser Roll featured a world-class field of wheelchair athletes as well as regional able-bodied runners in both 5 and 10 kilometer races.

Knaub, who won the Boston Marathon in 1 hour and 48 minutes finished in a time of 28:24. George Murray of Tampa, Fla., the first wheelchair athlete to break the 5 minute mile, finished second. Dean Barrett of Las Vegas, Nev., world wheelchair record holder of the 100, 200 and 400 meter dashes, finished third.

The first able-bodied runner to finish the 10 kilometer race was Nicholas Manciu of St. Paul, Minn., in 30:34.

Candice Cable, a wheelchair athlete from Las Vegas, Nev., won the female division of the 10 kilometer race in 34:55. Cable has been the fastest female wheeler in each of the last two Boston Marathons.

Over 1,800 racers, including approximately 60 wheelers and 12 blind athletes, participated in the event. The event was witnessed by several thousand spectators, and was telecast into thousands of additional area homes via cable.

Proceeds from the race, sponsored by the Kaiser Roll Foundation, will go to Camp Courage, Sister Kenny Institute and Vinland National Center.



Telephone Course Available To Hearing Impaired

The nation's first complete training program to teach hearing-impaired people to use the telephone successfully is now available nationally to schools and programs serving the hearing impaired.

Developed after 8 years of intensive research by Dr. Diane L. Castle at the National Technical Institute for the Deaf (NTID) at Rochester Institute of Technology (RIT), *Telephone Training for the Deaf* has been tested successfully on more than 200 students.

The package was developed for the hearing-impaired person who has some ability to talk and listen on the telephone with family and friends, but who wants to improve communication with strangers. The package has three components: complete illustrated text, student lab/homework sheets, and teacher materials (quizzes, answer sheets, etc.).

Dr. Diane Castle, who created the program, says it will teach hearing-impaired people how to use hearing aids and hard-of-hearing amplifiers with the telephone; what the different telephone signals mean; how to prepare to make a phone call; how to solve problems of understanding names, words or numbers; what to say in an emergency call; how to save money on long distance calls; and how to use different kinds of TDD equipment.

Telephone Training for the Deaf will be distributed by the Alexander Graham Bell Association for the Deaf, 3417 Volta Place, N.W., Washington, D.C. 20007. The full package, consisting of text, student materials, and teacher materials, cost \$19.95, plus \$1.80 for postage and handling. The text, alone, costs \$12.95, plus \$.75 for postage and handling.

Patient Education For Cord Injured People

June B. Mullins, Ph.D.,
and
Judith G. Bendel

For people of all ages, traumatic injury that results in sudden and substantial physical loss is an overwhelming and catastrophic event. Paralysis, sensory, or mental impairment requires an enormous readjustment. Research has shown that the person's psychological state is often a far more important factor in eventual good adjustment than the extent of the physical injury.

For several reasons, the spinal cord injured are of particular concern to professionals in education and rehabilitation. First, these patients are likely to be adolescents at the beginning of their lives and careers. (Their injuries have often been sustained in auto or sports accidents, and in violence or war.) Second, they must, after injury, attain a relatively high education to achieve vocational success. Third, a protracted hospitalization and medical rehabilitation leaves a hiatus in their regular schooling or reschooling. Fourth, although education is usually through salvation, they may feel so defeated and depressed that they may not only fail to prepare for a productive life, but may even neglect their physical needs, (which are considerable), even to the point of death through self neglect or suicide.¹ Studies indicate that younger injured people are inclined to be more debilitated and less independent than the older injured.²

The process of education and of rehabilitation and of psychological restitution itself are predicated on the patients' understanding and acceptance of their disability and their understanding of and cooperation in its treatment. Developing attitudes, knowledge, and skills are the province of *patient education*, which is to be distinguished from simply training patients to cooperate, comply, and accept what others tell them to do.^{3 4 5 6}

While patient education has been increasingly accepted as a concept, a number of researchers have come to

the conclusion that patients are still not well informed about their illness.^{7 8} Studies have shown that patients themselves are dissatisfied with their own limited knowledge.^{9 10 11}

The Bill of Patients' Rights of the American Hospital Association specifically states that patients have the right to obtain information concerning their illnesses. Patient education has been accepted by many in the United States and Europe as an integral part of the rehabilitation process. As the American Medical Association stated in 1976, "Information, motivation and participation in treatment by patients and their families, can aid the recovery of the patient and enhance the quality of his health. Patient education as an integral part of quality health care, provides an avenue to such improved participation."

Therefore, a number of professionals have encouraged efforts toward specific and formalized patient education programs for spinal cord injured patients.^{12 13 14 15 16}

The Survey¹⁷

The objective of the present study was to investigate practices with regard to patient education for spinal cord injured patients in rehabilitation centers associated with hospitals in the United States. The investigators were able to identify virtually all such centers. By means of a broad survey, some data on general practice in these centers were gathered. A detailed study investigated the implementation of patient education in 10 centers judged to be representative of all such rehabilitation centers.

Of the 124 hospitals serving spinal cord injured patients, 77 responded (62 percent return rate), and 76 of these reported having a patient education program. In these hospitals, the approximate number of patients served at a given time was 1,274 and about

one-fourth of the beds in the rehabilitation centers were occupied by spinal cord injured patients. The total number of staff members serving spinal cord injured patients was 4,483.

Ten of the rehabilitation centers representative in terms of type, size, and geographical distribution, were chosen to participate in a detailed survey. A "fact sheet" asked the attending physician about specific center characteristics.

Survey Findings

The 10 centers were surveyed to see if someone on the professional staff might be specifically designated as the patient educator. Several centers had educators who taught school subjects, but three specifically designated nurses and one psychologist as their patient educators. However, a majority of the centers did conduct formal patient education, and reported that much information was given on an informed basis. When asked what they emphasized in their programs, physicians, physical and occupational therapists, and some nurses emphasized the goal of patient education as physical restoration, while psychologists, social workers, and some nurses emphasized the patients' emotional restoration, as might be expected.

The areas of self care which were taught fell in the following categories: medication, diet control, bowel and bladder management, skin care, exercise techniques, and sexual functioning. Teaching in these areas was generally shared by nurses, physicians, and physical therapists. However, teaching with regard to sexual function was the primary role of 10 of the 11 psychologists who responded to the questionnaire, and many respondents felt that education with regard to sexual functioning was the most difficult for them to impart; albeit sexuality has been frequently demonstrated to be of pri-

mary importance to patients.^{18 19 20}

The study showed that various staff members were quite autonomous in their dealing with various aspects of patient education. They relied on staffings, the medical charts, and informal communication to coordinate their efforts. Most reported that they had little communication with the patient's family, and they were not particularly inclined to include the patient in their planning. There was wide variability in practice concerning staff-patient interaction. Personal interaction of any kind was discouraged as a matter of policy in one center, whereas 14 percent of all the staff had some interaction with patients outside of working hours.

In 2 of the 10 representative centers, patient education was clearly initiated in the acute ward. The other centers wait until patients are transferred to the rehabilitation unit to begin this work.

Types of materials used for patient education were researched. The most frequently used were information leaflets, audio-visual teaching aids, library books, and anatomical models. In some of the larger centers, closed circuit television, a telephone information line, and teaching machines are used. In addition, field trips are sponsored in one center, and role playing is used in another.

Special programs specifically designed for cord injured patients take place in three centers. In one, workshops for sexuality and social skills are held. In another, a special program teaches patients and their families about the center program. In still another, there is an optional group session that includes lectures by physicians or pharmacists, discussion about various aspects of the disability, and panel discussion with former patients. The family is invited to these sessions, in addition to an all day family group program.

Six centers also used some of the following techniques to evaluate the success of the program: a followup visit with the medical director; a pre- and post-rehabilitation questionnaire for the family; followup in the office or skin clinic; rehospitalization; out-patient recheck; periodic re-evaluation; and reports of home health personnel, either written or by telephone.

Discussion

Since 76 of 77 hospitals and rehabilitation centers offered some patient education, the process can be considered an important component of rehabilitation. Further, the study revealed that there is a large population of cord injured patients served in medical rehabilitation centers at any given time, and a considerable number of professionals serving them. However, it was evident that the goals and practice of patient education differed widely among centers and between and among professions in 10 centers.

Although the role of a patient educator has been identified in the literature, and as a specific professional role, only three centers employ a professional with that primary designation; that is, to instruct the patient in areas necessary for his mental and physical care as well as his vocational activities and to provide data about his psychological and physical progress for evaluation by the rehabilitation team. It was of great surprise that so few centers had a professional designated as a patient educator, who presumably would coordinate and systematize a patient educator program.

The patient educator role has not been developed fully, even in those centers where designated patient educators exist. The role description of the patient educator would suggest that he would be in a favorable position to coordinate the efforts of the rehabilitation team. There is a possibility that

some centers might implement more effective patient education if there were such a coordinator. Since special programs are available in a variety of centers, it would seem that they could be used in more centers serving cord injured patients and might be highly effective.

With respect to educational materials and methods, there was a lack of uniformity in practice. This might indicate that some centers might not be using the best combination of material and methods, at least for some people. However, some centers were using what appears to be very innovative materials and approaches to patient education.

Evaluation procedures differed widely, going from rather informal assessment of knowledge areas and observation of compliance to more structured techniques such as questionnaires, periodic interviews, and rehospitalization. It might be very helpful for the various rehabilitation centers to share their many systems of evaluation in order to ascertain which are the most useful and effective. Without a systematic structure for the evaluation, certain areas might be over-emphasized and others overlooked. This is an area of great concern since the literature stresses the high rate of patients' noncompliance with the medical regime and maintenance of health.

Although it would seem important to have the patient as an active member of the team, the study indicates this is not always encouraged. Since it is the patient himself who must eventually control his regime, it is important to involve him and his family or caretaker, since they can assist in the considerable adjustment after discharge from the hospital.

Of further note is the fact that neither rehabilitation counselors nor special educators seem to be much involved in the rehabilitation centers

at all. In view of the fact that most of the patients can be expected to return to the world of school or of work at the end of their stay at the center, it appears that these professionals, valuable to this transition, would be excellent additions to the staff.

Summary And Conclusion

The intent of the survey described was to discover the extent to which patient education for spinal cord injured patients, widely advocated in the professional literature, is practiced in representative rehabilitation centers. A number of professionals seemed to be involved in systematic and sometimes innovative practices. The investigators have concluded that educational management might be expanded and improved if communication and sharing within and between centers, and with patients themselves could be increased.

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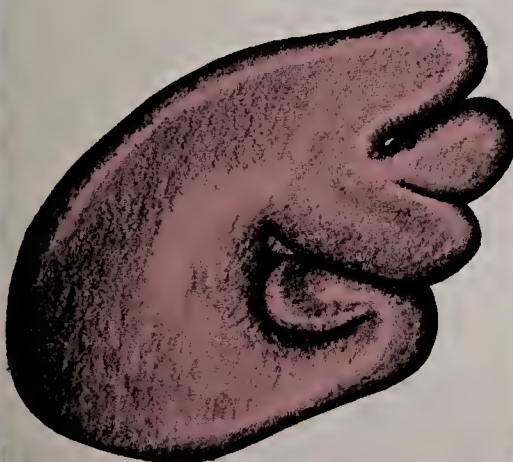
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(Continued on page 25.)

Speaking

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to

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The language of signs which most deaf persons use is another form of communication that anyone can learn.

Service agencies whose staff simultaneously sign and speak provide more and better services to their deaf clients.

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PUBLICATIONS & FILMS

Coed Prison. John Ortiz Smykla. Human Sciences Press, 72 Fifth Avenue, New York, New York 10011. \$19.95.

This text examines the administrative, interpersonal, and research issues related to sexually integrated prisons. Articles explore such issues as a comparison of the ways men and women adapt to co-ed prisons; rates of recidivism in co-ed and segregated institutions; feminist perspectives on sexual equality in integrated prisons; administrative methods for implementing co-ed facilities; professional evaluation and research techniques; interpersonal relations among inmates; and examinations of specific facilities and programs.

Advancing your citizenship: Essays on consumer involvement of the handicapped. Browning, P., Rhoades, C., & Crosson, A. University of Oregon, Rehabilitation Research and Training Center in Mental Retardation, 2nd Floor Clinical Services Building, Eugene, Oregon, 97403. \$5.

This monograph is the third in the *Advancing Your Citizenship* series. It is a collection of 10 essays on the development of consumer involvement of handicapped people.

The first section traces the history and evolution of the consumer movement of the handicapped, discusses ways of practicing consumerism, and considers consumer issues unique to the mentally retarded people.

The essays in the second section address the legislative making of consumer rights and mechanisms for the implementation of those rights, e.g. civil rights, individualized programs,

independent living, client assistance projects, procedural safeguards, etc.

The two monographs preceding this one are *An Advocacy Manual for Persons with Disabilities* and *An Annotated Bibliography on Consumerism/Advocacy for Persons with Disabilities*. The series materials are an outgrowth on works being done in the area of consumerism/advocacy for disabled people at the University of Oregon Rehabilitation Research and Training Center in Mental Retardation.

The Interdependent Community: Collaborative Planning for Handicapped Youth, Leader's Handbook and Member's Guide by Paul Ferrini, Bradford L. Matthews, June Foster, and Jean Workman. Technical Education Research Center, 44 Brattle Street, Cambridge, Mass., 1980. Paper, \$10. per set.

"How can we improve services in an era of shrinking funding?" is a critical question for any organization serving individuals with special needs. Collaboration with other organizations in the community offers an answer, creating access to more data, expanded services, new clients, and shared facilities.

A new set of publications, designed to help organizations collaborate successfully, has just been completed by the Special Needs Program of TERC. The books are intended for use by a team whose leader and members share a concern for improving career opportunities for disabled students, though many of the techniques discussed could easily be adapted for use by groups with another focus.

The Interdependent Community: Collaborative Planning for Handi-

capped Youth, Leader's Guide contains:

- Guidelines for assembling a local planning team composed of representatives from various sectors of the community—schools, handicapped service organizations, government agencies such as vocational rehabilitation, and businesses;

- Step-by-step instructions for a process which helps the team collaboratively identify, plan, and implement the services most needed by disabled students;

- Tips for managing conflicts among team members and for handling difficult tasks, such as allocating responsibility and coordinating implementation, which often slow the positive momentum of collaborative efforts;

- Information, identified through a national survey, about existing collaborative programs, about organizations presently collaborating, and about the attitudes of organizations toward each other and toward the process of collaboration itself; and

- Names and addresses of sources of additional information, materials, and assistance.

The accompanying *Member's Guide* outlines the step-by-step collaborative process and discusses the responsibilities of team participants as they interact with each other to accomplish the task at hand.

Leisure Programs For Handicapped Persons. Paul Wehman and Stuart Schleien with a contribution by Ronald P. Reynolds. University Park Press, 300 Charles St., Baltimore, Md. 21201. 266 pages. \$21.95.

The book's 10 chapters survey normalization, leisure skills assessment, leisure instruction (writing behavioral objectives, task analysis and skill sequencing, etc.), adapting leisure skills (the modification of activities that allow full or partial participa-

tion), curriculum design and format, program implementation (with case studies).

Chapters 6, 7, 8, and 9 look into hobbies, sports, games, and object manipulation (blocks, crayons, frisbees, marbles, etc.).

The Handicapped Speak. William Roth. McFarland and Company, Inc., Box 611, Jefferson, N.C. 28640. 211 pages. \$15.95.

This is a book about triumph, about failure. It tells of hope and discouragement. With coping. With tears and laughter. It is the story of 13 men and women and children. In their own words. And they "tell it like it is."

But, aside from the chronologies of their lives, the author points out in his introduction that "fundamental changes in public policy are necessary. It is vital that policy makers listen and understand before wasting dollars on ineffective policy. For instance, what kinds of housing, transportation and education are appropriate for handicapped people? The issue of work is of central importance. If many disabled people can and want to work, then the current transfer system which frequently makes work financially costly, must be recalibrated. The current policy, attempting to increase the supply of disabled workers, should be coupled with a policy to increase the economy's demand for disabled workers."

Following the personal stories, the author presents an epilog that comments on transportation and work.

The Disabled Homemaker. Hoyt Anderson. Charles C Thomas, 301-327 East Lawrence Ave., Springfield, Illinois 62717. 343 pages. \$19.50 (cloth); \$12.75 (paper).

From the Foreword by Ed Roberts, director of California's Department of Rehabilitation:

"...this is more than a specialized collection of household hints. Underlying the book is a real belief in people and what they can accomplish. There is encouragement here, the encouragement that comes from real life examples of disabled people who have successfully put the pieces of the independence puzzle together and are leading active and satisfying lives. Running all through the excellent, practical advice in *The Disabled Homemaker* is the realization that the goal of independence is possible—that others have tried and succeeded, and found it to be well worth the effort."

Assessment And Planning With The Visually Impaired. Charles J. Vander Kolk. University Park Press, 300 North Charles St., Baltimore, Md. 21201. 224 pages. \$24.95.

This book compiles information about the vocational, developmental, psychosocial, and intellectual domains of blind people.

From the Preface: "I approached writing this book with the assumption that a comprehensive and careful assessment of the individual and his or her environment is necessary before we can make plans, set up a program, or believe we truly understand that person. ... There is a need for rehabilitation workers and educators to know how to execute a meaningful assessment. This book may be helpful to them."

Lip Reading. Edward F. Walther. Nelson-Hall Publishers, 111 N. Canal Street, Chicago, Ill. 60606. 181 pages. \$19.95, hardcover.

Illustrations and exercises help the reader master lip reading. Various drills promote the recognition of short, long, and compound words as well as the lip movements involved in various vowel and consonant sounds and com-

binations. The author draws on his own hearing impairment and the years he has spent teaching lip reading in presenting this self-teaching course.

Disabled People As Second-Class Citizens. Volume 2. Myron G. Eisenberg, Ph.D., Cynthia Griggins, and Richard J. Duval, editors. Springer Publishing Company, 200 Park Avenue South, New York, N.Y. 10003. 300 pages. \$26.95, hardcover.

Nineteen authors contribute to this, the second volume in the Springer Series on Rehabilitation.

Quoting from the introduction: "The text is divided into four parts. The first two parts concentrate on describing the situation facing the disabled person and exploring reasons for the discrimination that is met. The last two parts offer ideas on how such discrimination might best be met and dealt with by individuals and by organized groups."

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Classifying VR Program/System Indicators

Sita Misra, Ph.D., M. S. Tseng, Ed.D., and Ranjit K. Majumder, Ph.D.

Since its inception in 1920, the rehabilitation program has experienced tremendous growth, from a modest restoration program for the physically handicapped to one now mandated to serve all disabled people in achieving their potential. A close scrutiny of the data (RSA statistics), however, reveals that the growth in rehabilitation activity has not been free from fluctuations, as shown in Figure 1. Why did these fluctuations occur? What caused the fluctuations? Were they caused by some internal program changes or by external factors? Not enough effort has been made to seek answers to these questions.

In economics, fluctuations in aggregate economic activity are usually explained with the help of business cycles and several economic indicators.^{1 2 3 4 5 6 7 8 9} These indicators are used to explain, forecast, and control economic behavior. They have been developed over the years, based on the observations of what had actually happened during the ups and downs of the economy; they are not principles deduced from a comprehensive theory, but are an example of inductive or empirical discovery. Nevertheless, they do make logical sense when interpreted as a rough analysis of the business cycle.

Some of these indicators are: Average work week in manufacturing (hours); housing starts (millions); corporate profits (billion \$'s, annual rate); changes in business inventories (billion \$'s); employment and unemploy-

ment; Gross National Product in current and constant dollars (billion \$'s, annual rate); personal income (billion \$'s, annual rate); wholesale price index, excluding farm products and food; and bank interest rate, business loans (percent).

Similarly, fluctuations in rehabilitation activity must be explainable through rehabilitation indicators. Though program evaluation has been legislated and has become an integral part of the rehabilitation program, only recently has it gained much attention and importance. At present, no comprehensive listing of macro and micro rehabilitation program/system indicators exists which could assist rehabilitation practitioners and administrators pinpoint easily and promptly the problems within the overall system.

The project which has since been completed by the New York Medical Center¹⁰ identifies what may be termed as client-centered process facilitative indicators. The Berkeley Planning Associates¹¹ have addressed the need for program evaluation standards which border along the issue of measurement of rehabilitation outcome. The Abt Associates¹² have attempted to identify appropriate data elements for evaluation purposes. But these studies stop short of explaining the fluctuations in rehabilitation cycles. Therefore, there is a great need for identifying rehabilitation program/system indicators.

Development of exhaustive micro and macro rehabilitation program/system indicators would not only facili-

tate self-evaluation of rehabilitation counselors and professionals and in-house program evaluation of the state VR agencies, but also would provide a more meaningful and useful tool at the federal level for policy and decision-making. This paper addresses such issues.

Of course, one can speculate and attribute these fluctuations to the incremental legislative history of rehabilitation: Smith-Fess Act of 1920; Barden-LaFollette Act of 1943; Vocational Rehabilitation Amendments of 1954 (P.L. 83-565); VR Amendments of 1965 (P.L. 89-333); VR Amendments of 1968 (P.L. 90-341); the Rehabilitation Act of 1973; and the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, which, in turn, altered the policy and the scope and magnitude of services provided to handicapped people. This means the roles, responsibilities, and duties of the state-federal vocational rehabilitation agencies have constantly changed as the law changed.

The chain of command is long—beginning with the Congress and ending with the rehabilitation counselors who work directly with the clients. Therefore, any change along the chain is likely to impact the provision of rehabilitation services, thereby causing fluctuations within the program. These fluctuations are explainable with the aid of *program indicators*.

No program operates in a vacuum; the environment in which it operates considerably influences its activities.

Figure 1
NUMBER OF PERSONS REHABILITATED, FY 1921-1978

Thousands of Persons

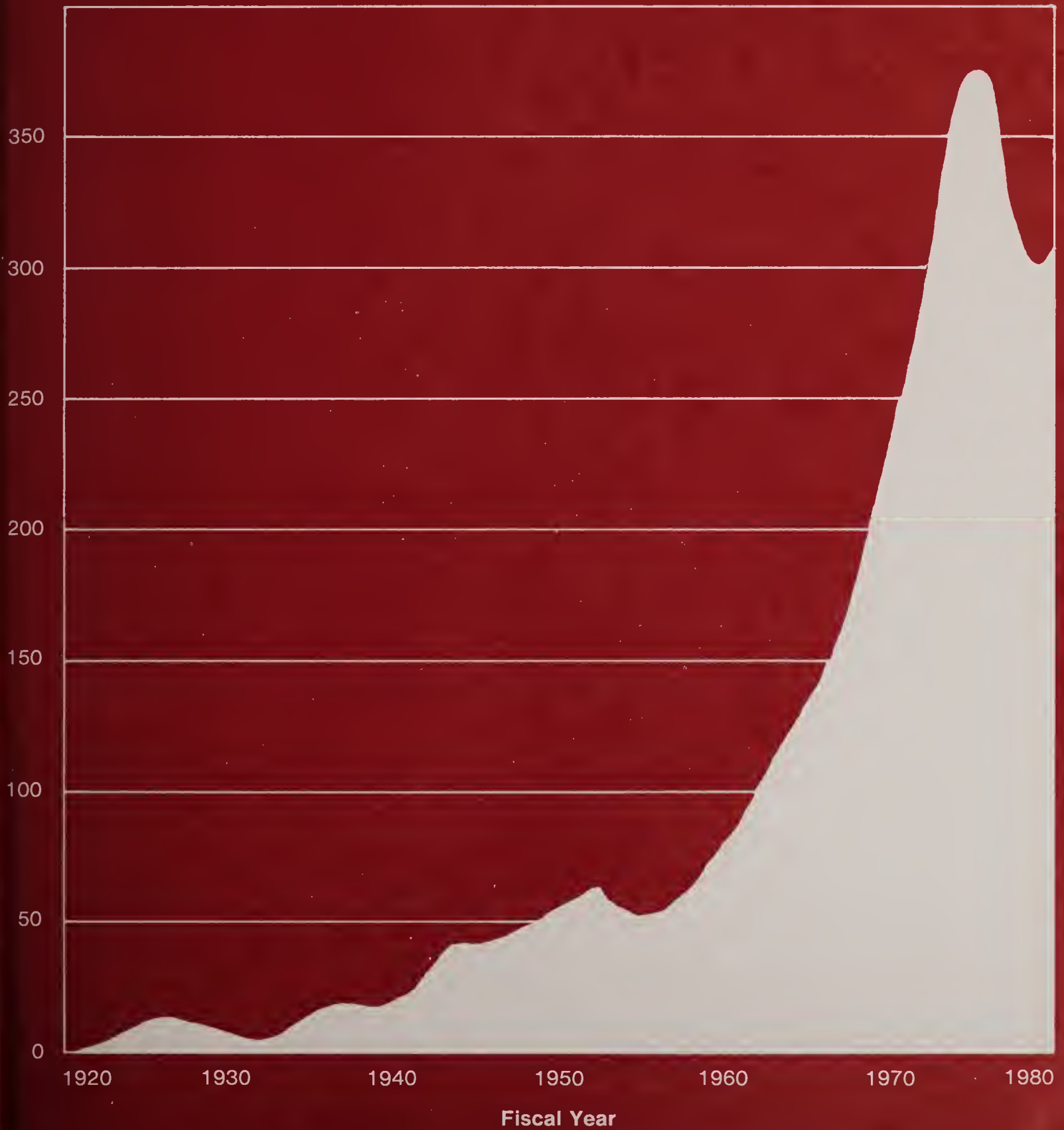
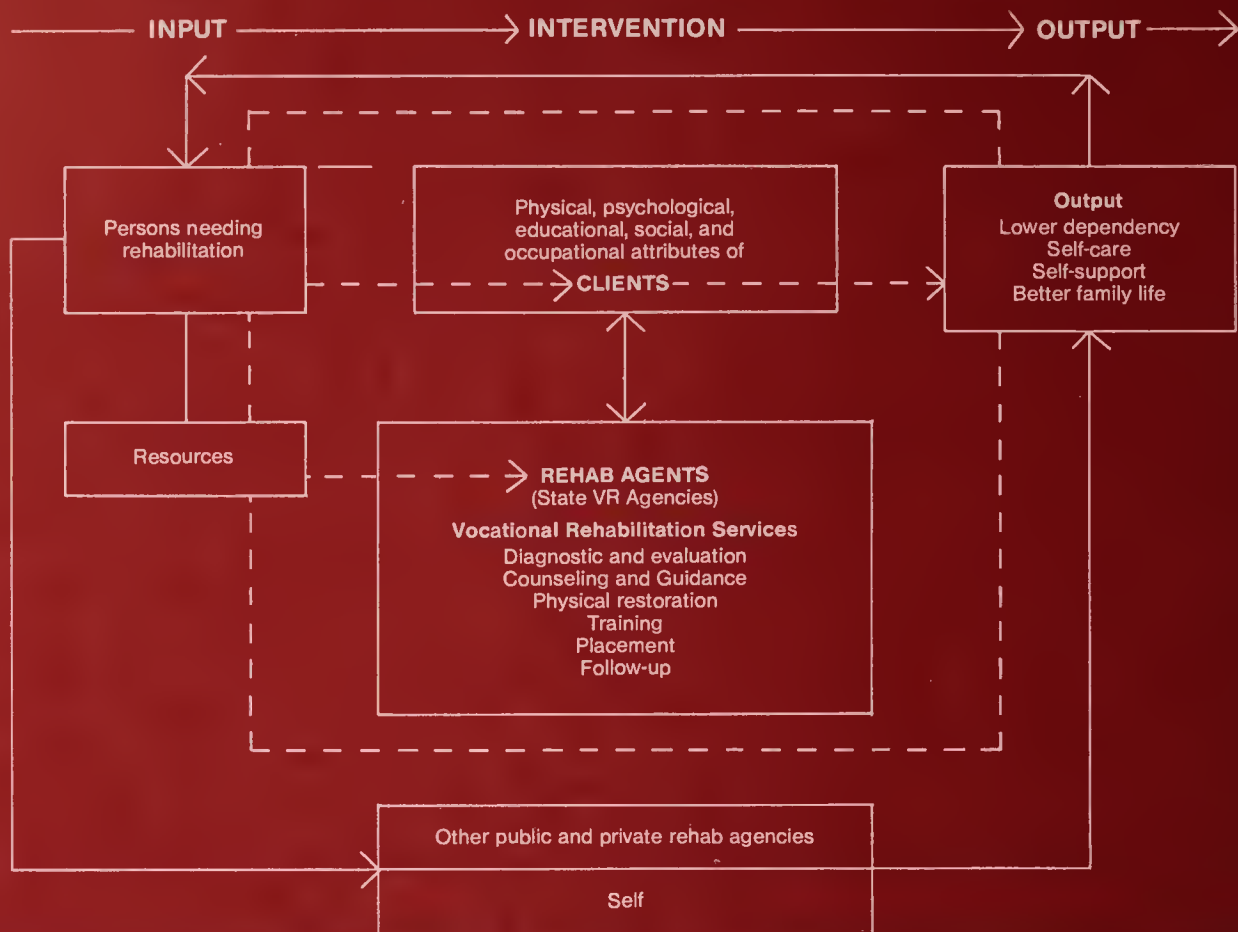


Figure 2
VOCATIONAL REHABILITATION SYSTEM



Because of this interdependence and interaction between the program and the environment, the indicators need to be classified into two groups:

- *Endogenous program indicators*, which help explain fluctuations within the rehabilitation program.
- *Exogenous program indicators*, which help explain fluctuations in the rehabilitation activities due to environmental factors.

Developing these indicators are useful in facilitating and guiding future actions of legislators, policymakers, and administrators.

While the indicators help explain program fluctuations, they are not adequate in explaining fluctuations that occur within the core of the program, *i.e.*, the *rehabilitation service delivery system*. To examine core fluctuations, we need to investigate the service delivery system at work.

In a macro fashion, the functioning of the rehabilitation service delivery system has three basic components (input, intervention, and output) which constitute a looping cycle (see Figure 2).^{13 14}

Included in the *input* end are persons who need rehabilitation, and those who serve as rehabilitation resources (family, community, and world of work).

The second component, *intervention*, represents a phase during which vocational rehabilitation takes place. The disabled person may complete intervention entirely on his own resources, through the assistance of public and private agencies other than those of vocational rehabilitation, or via the services of vocational rehabilitation agencies.

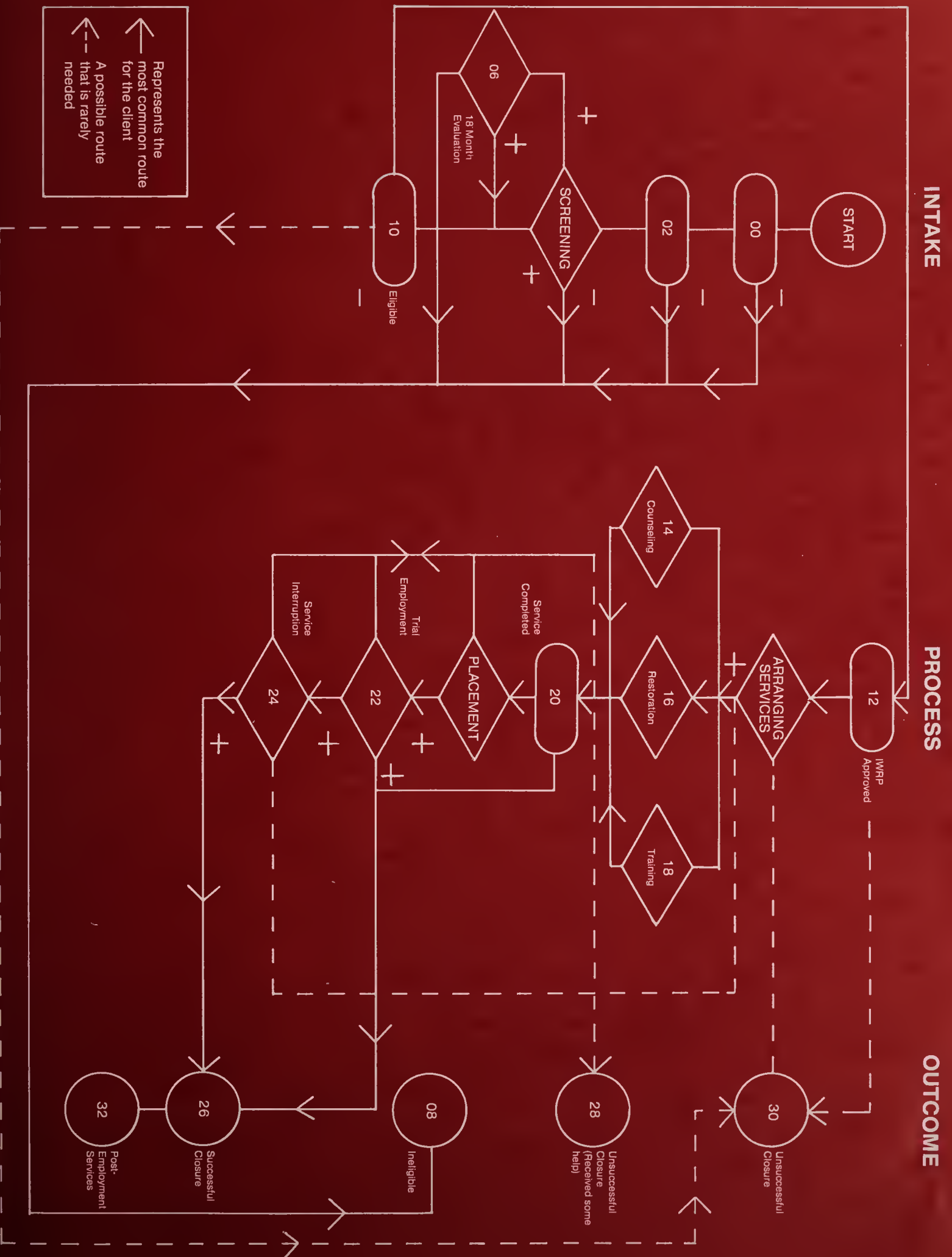
The primary role of the vocational rehabilitation agencies is portrayed in Figure 2 by the largest box (formed by broken lines) in which diagnosis and evaluation, counseling and guidance, physical restoration, training, placement, and followup services are to serve as vehicles for intensive client-rehabilitation agent interactions. The client comes to the VR agency with his physical, psychological, educational, social, and occupational strengths and weaknesses. The rehabilitation agent who is there to help the client, too, brings his background and personal attributes into the picture. Interactions between the client and the rehabilitation agent through various services allow the pooling together of the client's own resources and the environmental resources that are crucial in enhancing and facilitating his rehabilitation.

The client then returns to the community (*output*) with his dependency lowered, self-care improved, self-support attained or retained, and family life strengthened in the output. He might either become part of the rehabilitation resources in the input stage or return as a person needing further rehabilitation and repeating the rehabilitation cycle.

Though all three components are interlaced, input and output are more general in nature and can be handled with much ease. However, intervention, which is the crux of the rehabilitation system, is more elaborate and detailed. This component, better defined by the vocational rehabilitation caseload statuses as shown in Figure 3¹⁵, is, operationally speaking, a common knowledge to VR professionals. The intervention component consists of three stages: intake (statuses 00, 02, 06, and 10); process (statuses 12, 14, 16, 18, 20, 22, and 24); and outcome (statuses 26, 28, 30, and 08).

An empirical classification of system indicators may be advanced on the basis of this input-intervention (intake-process-outcome)-output paradigm by taking into consideration several dimensions, *i.e.*, human, time, and cost elements.

Figure 3
INTERVENTION COMPONENT OF THE VOCATIONAL REHABILITATION SYSTEM



The system indicators may be developed and classified into two groups:

- *Macro system indicators*, which may help explain fluctuations within the system as a whole, *i.e.*, along the input-intervention-output continuum, but more specifically in relation to input, intake, process, outcome, and output components, considering more than one component regardless of the number of dimensions (human, time, cost, etc.).

- *Micro system indicators*, which help explain fluctuations within any *one* of the components of the system input or (intake or process or outcome or output) across one or several dimensions.

For example, a micro system indicator in the cost dimension for the process component may be:

$$\text{Restoration} = \frac{\text{Dollars spent on clients in status 16}}{\text{Dollars spent on all clients}} \times 100$$

$$\text{Cost Index} = \frac{\text{Dollars spent on all clients}}{\text{Dollars spent on clients}}$$

A micro system indicator in the time dimension for the process component may be:

$$\text{Placement Time Index} = \frac{\text{No. of months spent by clients in statuses 20-22}}{\text{No. of months spent by clients in 00-24}} \times 100$$

Similarly, a macro system indicator in the human dimension across the intake-process-outcome may be:

$$\text{Caseload Index} = \frac{\text{No. of all clients in all statuses}}{\text{No. of counselors}}$$

Another macro system indicator in the cost dimension across the intake-process-outcome may be:

$$\text{Rehabilitation Cost Index for Severely Disabled} = \frac{\text{Dollars spent on severely disabled}}{\text{Dollars spent on all clients}} \times 100$$

These and other system indicators may be computed overall or by certain specific classification of clients, such as disability, sex, race, education, etc.

For most of the system indicators, the base could be temporal. The efficacy of these and other system indicators can be established only after empirical validation based on the past data.

In its 17 years of performance as a Research and Training Center, the West Virginia center has placed considerable emphasis on program evaluation, pioneering in both research and training in this field. For example, the Profile Analysis Technique (PAT), the Preliminary Diagnostic Questionnaire (PDQ), and the Vocational Behavior Checklist (VBC) are some of the significant evaluation tools which the center has developed as a result of the RSA Region III Program Evaluation Forum, the brainchild of the center.

The center has also established the most extensive and sophisticated data analytic resource, dedicated to the analysis of rehabilitation in the nation. It has retrieved and stored 9 million vocational rehabilitation case service records for the years 1971-1980.

Committed to the concept of program evaluation, the center has begun a special research project to develop a set of program/system indicators (both micro and macro) based on the past performance of vocational rehabilitation, and to determine empirically their use in monitoring the health of vocational rehabilitation. The authors believe that development of exhaustive micro and macro rehabilitation system indicators would not only facilitate self-evaluation of rehabilitation counselors and professionals and in-house program evaluation for the state VR agencies, but also provide a more meaningful and useful tool at the federal level for policy decisionmaking and also for seeking Congressional support for additional appropriations. The indicators should help explain, forecast, and control the activities of vocational rehabilitation.

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REPORT RESOURCES

ACCESS: NEW YORK CITY. The Junior League of the City of New York, Inc. 130 East 80th Street, New York, N.Y. 10021. \$2.

AN EXPLORATORY STUDY OF MUSEUM CHARACTERISTICS IN SELECTED WASHINGTON, D.C. MUSEUMS, RELEVANT TO EDUCATION OF THE DEAF. (Doctoral dissertation.) Sandra Platt Novik, Ed.D., University of Maryland 1981. UMI, 300 N. Zeeb Road, Ann Arbor, MI 48106. (800) 521-0600.

ADVANCING YOUR CITIZENSHIP: NORMALIZATION RE-EXAMINED. Gilbert Foss, editor. (Proceedings of a National Conference on Normalization and Contemporary Practice in Mental Retardation) Rehabilitation Research and Training Center in Mental Retardation, University of Oregon, Eugene, Oregon 97403. \$5.

SELECTED ASPECTS OF FINANCIAL MANAGEMENT IN REHABILITATION FACILITIES: A RESOURCE MANUAL. Jerome R. Lorenz, Chris S. Graham, Patsy L. Hashey, and Richard J. Baker. (A publication of the National Association of Rehabilitation Facilities) Materials Development Center, University of Wisconsin, Menomonie, Wisconsin 54751. \$14 (members), others, \$18.

HANDICAPPED FUNDING DIRECTORY. 1982-83 edition. Burton J. Eckstein. Research Grant Guides, P.O. Box 357, Oceanside, N.Y. 11572. \$18.

CARING FOR THE PATIENT IN HALO VEST TRACTION: A GUIDE FOR PATIENTS, FAMILIES AND

STAFF. (Patient publication no. 6) Institute of Rehabilitation Medicine, 400 East 34th Street, New York, N.Y. 10016. \$3 (Make checks payable to NYU Medical Center).

INDEPENDENT LIVING: AN OVERVIEW OF EFFORTS IN FIVE COUNTRIES: DENMARK, FEDERAL REPUBLIC OF GERMANY, YUGOSLAVIA, COSTA RICA, AND JAPAN. Denise Galluf Tate, Ph.D., and Linda M. Chadderdon, UCIR, University Center for International Rehabilitation, Michigan State University, East Lansing, MI 48824. Domestic, \$4.75; Foreign, \$5.

BULLETIN OF PROSTHETICS RESEARCH. REHABILITATIVE ENGINEERING RESEARCH AND DEVELOPMENT. Fall 1981. Veterans Administration, Department of Medicine and Surgery, Washington, D.C. 20420.

INTERNATIONAL SYMPOSIUM ON SERVICES FOR YOUNG DISABLED CHILDREN, THEIR PARENTS AND FAMILIES. Proceedings: Discussions and Implications for Future Activities. December 1981. Research Assessment Management, Inc., 1320 Fenwick Lane, Suite 105, Silver Spring, MD 20910.

SOCIAL JUSTICE THROUGH HANDICAPPED POWER: PERSPECTIVES FROM ENGLAND AND SWEDEN. G. D. Carnes, Ph.D. University Centers For International Rehabilitation, Michigan State University, 513 Erickson Hall, East Lansing, MI 48824. (Research sponsored by the World Rehabilitation Fund)

(Tape copies available through the Michigan Library for the Blind through your regional library for the blind.)

RESEARCH REPORT OF THE INTERDEPARTMENTAL WORKERS' COMPENSATION TASK FORCE. Volume 1. Workers' Compensation Reform: Challenge for the 80's. Ronald Conley, Ph.D., and John Noble, Ph.D. U.S. Department of Labor, Employment Standards Administration, Washington, D.C. 20210.

FOUR PUBLICATIONS: Lobbying For The Rights Of Disabled People: Views From The Hill And From The Grass Roots; Financial Resources For Disabled Individuals; Learning To Live With Disability: A Guidebook For Families; Hiring And Supervising Personal Service Providers: A Guide. These are available, while the supply lasts, from National Rehabilitation Information Center, 8th and Varnum Streets, N.E., The Catholic University of America, Washington, D.C. 20064. \$1. per book.

THE SELECTIVE GUIDE TO AUDIOVISUALS FOR MENTAL HEALTH AND FAMILY LIFE EDUCATION. Marquis Academic Media, 200 East Ohio Street, Chicago, Illinois 60611. \$29.50 plus \$2.50 postage and handling.

DIRECTORY OF FACILITIES SERVING DISABLED PEOPLE. Commission on Accreditation of Rehabilitation Facilities, 2500 North Pantano Road, Tucson, Arizona 85715. \$10.

SUGGESTED GUIDELINES FOR EVALUATING WORK SAMPLES. Paul McCray. Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin-Stout, Menomonie, Wisconsin 54751. \$2.

NEWS, NOTES, ANNOUNCEMENTS

HARD QUESTIONS 1980. (Annual Report) Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711.

ADAPTABLE HOUSING. A manual for minimal accessible housing for private sector construction and renovation. Access Living of Metropolitan Chicago, 505 N. LaSalle, Chicago, Illinois 60610.

LIVING WITH CYSTIC FIBROSIS (16mm or ¾" videocassette) Free loan. Association Films, 866 Third Avenue, New York, N.Y. 10022. 36 minutes.

DEVELOPING THE REHABILITATION FACILITY PERSONNEL MANUAL. Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin, Menomonie, Wisconsin 54751.

MENTAL DISABILITY LAW REPORTER. (6 issues per year) American Bar Association, 1800 M Street N.W. Washington, D.C. 20036. \$50 per year.

PUBLIC RELATIONS FOR REHABILITATION FACILITIES. Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin, Menomonie, Wisconsin 54751.

REHABILITATION INTERNATIONAL VOCATIONAL SEMINAR. Employment of the handicapped—the goal of integration and safety in the workplace. Vocational Rehabilitation Center of Allegheny County, 1323 Forbes Avenue, Pittsburgh, Pennsylvania 15219. \$9.

Link Found Between LD And Juvenile Delinquency

A research organization in Williamsburg, Virginia, has found evidence that learning disabled boys are more likely to commit violent crimes, steal, drink, use drugs, and have discipline problems in school than other boys. The study also found that learning disabled boys who get caught for their crimes are more likely to be arrested and go to trial than equally delinquent boys without learning problems.

According to the Report on Educational Research, National Center for State Courts researchers tested and interviewed in 1977 a cross-section of 1,943 youths from public schools, juvenile courts and prisons in three major cities. In 1980, they again tested and interviewed a group of 351 youths from the original study who had no history of delinquency before the research began. Twenty-six percent of the first group and 16 percent of the second had learning disabilities.

While researchers identified a link between learning disabilities and delinquency, it also was found that remediation produced modest gains in academic achievement and significant reductions in delinquency. The study is not the first investigation of learning disabilities and juvenile delinquency; other researchers also have found a correlation between the two factors.

NCSC's final report is not yet available, but the initial report can be obtained for \$1.50 from the Publica-

tions Coordinator, National Center for State Courts, Newport Avenue, Williamsburg, Virginia 23185.

Placement, Research And Training Center Is Established

The National Institute of Handicapped Research has awarded a grant to the Human Resources Center, Albertson, New York and New York University to establish a Placement, Research and Training Center, reflecting the federal emphasis on job placement as a key component in the rehabilitation process.

The center will improve the training and expertise of rehabilitation professionals in job placement, often given minimal attention in graduate rehabilitation counseling programs. HRC will conduct research studies and in-service training programs for counselors on topics relevant to job placement and Projects With Industry.

New York University will be responsible for integrating research findings into educational programs for training rehabilitation counseling students in the theory and practices associated with placement and career development for handicapped persons.

The increases in federal funding for Projects With Industry and the new training priorities established by Rehabilitation Services Administration Commissioner George Conn illustrate the impact of the job placement emphasis in rehabilitation. The new center is expected to help professional counselors prepare for the challenge of placing handicapped persons in a high-

ly competitive market calling for creative collaborations with business and industry.

Parking Tickets Can Be Issued By Citizens

Have you ever seen a car illegally parked in a handicapped zone—and wanted to do something about it? Daniel Freeman Hospital Medical Center, 333 North Prairie Avenue, Inglewood, California, 90301 will supply you with a “parking ticket” that you, yourself can issue.

It's not really a parking ticket and there is no fine involved. But it is a reminder—a reminder that handicapped spaces are provided for those people whose limited mobility makes reserved parking a necessity.

Jeffery B. Klein, Daniel Freeman's Vice President of Rehabilitation Services, is an avid user of the parking tickets. “I'm always annoyed when I see people illegally parking in handicapped zones,” said Klein. “But when I walk up to someone and point it out, they know they're wrong and usually become belligerent.

“Instead of confronting them personally, I now put a parking ticket on their windshield and that gets the message across.”

EEG's To Sort Out Brain Signals In Learning Disabled

The hypothesis is that communication between certain brain regions is not as efficient in the learning-disabled child as in the normal child.

The method for testing the theory, explains Dr. Bernard Saltzberg, chief

of the information analysis section, “involves analyzing electrical signals recorded from different brain regions, then computing the amount of shared information between them.”

The measure of shared activity between two EEG signals is, in signal-processing theory, called “spectral coherence.”

Miles of tape—electroencephalographic records of children with various types of learning problems—are being analyzed in his section. Saltzberg hopes to design a method of identifying the brain mechanisms that underlie learning problems. The goal down the road is to develop a classification system of learning disorders based on understanding the brain activity that is related to learning.

Saltzberg is widely known for the detection of brainwave spiking, and he is, not surprisingly, more at home with the vocabulary of mathematics and computer analysis, than with lay language.

Saltzberg is studying EEG data from 20 children with learning disorders and a control group of 15 age-matched normal learners. While their EEGs are being recorded, the children perform language and word recognition tasks, they match shapes and solve other kinds of problems believed to activate certain areas of the brain.

The project is a collaborative study with systems analyst William Burton, Dr. Robin Michael of the University of Texas department of psychiatry, and Dr. Jack Fletcher, chief of the TRIMS neuropsychology section. Fletcher and Michael selected the children, designed test protocols, and conducted the neuro-psychological evaluations.

“We are trying to find out whether regions of the brain communicate in specific ways in certain cognitive

states,” Saltzberg explains. But, because the EEG of a learning-disabled child is perfectly normal superficially, the research requires deeper and more detailed analysis of multiple-channel EEGs than is required for an ordinary EEG evaluation.

Saltzberg and Burton use what they call a “frequency microscope”—the spectral coherence formula applied to the record via computer—to identify the level of shared activity between EEG channels.

“We are trying to find out what takes place within the brain in response to different stimuli and what pathways are involved when the brain is processing visual and auditory stimuli,” Saltzberg says. “If we learn what brain pathways are activated in reading, for example, we may then be able to train a learning-disabled child to activate that pathway as a possible remedial measure.”

The Emissary, Texas Research Institute of Mental Science, Houston.

VR INDICATORS

(Continued from page 30.)

12) Abt Associates. Comprehensive management information system for the state/federal VR program. July, 1981.

13) Tseng, M.S. Job performance and satisfaction of successfully rehabilitated vocational rehabilitation clients. *Rehabilitation Literature*, 1975, 36, 66-72.

14) Walls, R.T., & Tseng, M.S. Measurement of client outcomes in rehabilitation. In B. Bolton (Ed.) *Measurement and Evaluation in Rehabilitation*. Baltimore, MD: University Park Press, 1976.

15) Leary, P.A., & Tseng, M.S. The vocational rehabilitation process—explained. *Journal of Rehabilitation*, 1974, 40, 9 & 34.

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November - December 1982

AMERICAN REHABILITATION



LD Adults: Challenge

Adjustment In MS

Projects With Industry

Med Care For Children

Notice To Readers

Because of budgetary constraints, *American Rehabilitation* is forced to reduce its production by two issues a year. Beginning with the New Year, *AR* will publish quarterly in January, April, July, and October. The number of pages will remain substantially the same.

Paid subscribers should receive adjustment notices from the Superintendent of Documents, U.S. Government Printing Office.

The Agency and staff have every intention of continuing its tradition of coverage of the entire field of rehabilitation. They will continue to solicit materials for its pages and receive nonsolicited materials equally. Department offerings will remain the same.

AMERICAN REHABILITATION

Volume 8, Number 2 The weakest ink is better than the strongest memory. November-December 1982

3	Projects With Industry	Irwin Kaplan and Norman Hammond
9	Vocational Adjustment In Multiple Sclerosis	Nicholas G. La Rocca, Ph.D., and Nancy J. Holland, R.N.
19	View From The Castle	Thomas Brubeck
23	The LD Adult: Administrative Challenge	Dale Brown
28	Managing Medical Care For Children With Chronic Disabling Conditions	Paul A. Sommers, Ph.D.

DEPARTMENTS

2	Topic of State	16	Notes on the Margin
8	Language Used	18	Report Resources
14	New Publications	22	News, Notes, Announcements

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TOPIC OF STATE

Project Has Positive Effects On Awareness

PROJECT INTERDEPENDENCE is growing by the proverbial leaps and bounds as more people are becoming involved in this grass roots effort to increase awareness of the strengths of high school youth, with and without disabilities. Inaugurated last year as rehabilitation's major IYDP initiative, PROJECT INTERDEPENDENCE represents a longterm commitment bringing together public agencies and private business to work on a statewide program aimed at increasing community organization at the local level. The State Department of Education is a full-fledged partner with the help of Parks and Recreation and California Conservation Corps.

The project started on a small scale last year with 100 sophomore and junior students from 11 high schools throughout the state gathering at a wilderness camp in La Honda. At this first "Discover Interdependence Week," these students, half of whom had disabilities, participated in training sessions and activities designed to increase their mutual recognition and friendship and to learn basic organizing and leadership skills. They then went back to their schools and communities to initiate activities in the sciences, arts, integrated sports, recreation, careers and disability awareness, to encourage integration of people with disabilities into all areas of life.

This year, thanks in part to a \$10,000 donation from Pacific Telephone, 80 additional students from eight new high schools and 20 students from last

year's 10 schools will be participating in the Discover Interdependence Week scheduled for August 29 to September 3. In addition, a film is being produced on PROJECT INTERDEPENDENCE for commercial use with Twentieth Century Fox, which is underwriting the entire cost of the production.

—*Rehab Review*, California Department of Rehabilitation.

Regents Confirm Actions On OVR Amendments

In the February 24-25 meeting, the regents confirmed action on the following amendments to the Regulations of the Commissioner of Education pertaining to vocational rehabilitation which had been approved on an emergency basis in the December meeting:

Individualized written rehabilitation programs — Individually written rehabilitation programs are currently prepared for all clients which set forth the terms and conditions under which services are to be rendered. The amendment stipulates that these written plans are not legal contracts and may be modified when they are reviewed, which is required at least annually.

Rehabilitation services available — Authorizes the Office of Vocational Rehabilitation to establish written policies which define the scope and nature of services available to clients. Up to now, this authority has been contained only in federal regulations.

Financial need for vocational rehabilitation clients — Because of reductions in the amount of federal money available for vocational rehabilitation services, more stringent financial eligibility requirements may need to be imposed on certain SSI/SSDI clients. The amendment

provides that recipients of Social Security Disability benefits and Supplemental Security Income may be required to prove financial need. These individuals were previously exempt from this requirement.

Maximum levels of State support — Also as a result of reduced federal funds, the Office of Vocational Rehabilitation has found it necessary to set upper limits on the amount of state support it will pay for tuition and supplemental allowances for food and shelter during client training programs. The amount of \$1,350 per year for food and shelter has been set. Out-of-state training has been restricted to certain specified circumstances, and foreign training has been completely abolished.

In their May 20-21 meeting, the Regents confirmed the maximum level of \$1,000 per year for college, business college or university tuition reimbursement. This amendment had been approved at an earlier meeting of the Board of Regents.

—*OVRSun*, Office of Vocational Rehabilitation, Albany, NY.

Wisconsin Center To Open Hydroponic Greenhouse

The Calumet County New Hope Center, Chilton, will soon be opening its *hydroponic greenhouses* at the south end of the city. The project site is near the city incinerator, which it is hoped can be a source of heat in the future. The greenhouses were built with a community development block grant and a loan from the Commercial Bank of Chilton. The project encompasses a 30 x 124 foot lettuce house and a 65 x 128 foot tomato house. Future plans call for addi

(Continued on Cover III.)

Projects With Industry: The Concept And The Realization

Irwin Kaplan and Norman Hammond

In the United States, the rehabilitation and reemployment in competitive positions of disabled people has often been unsuccessful because of one or more of the following:

- The job training given has not provided the skills actually needed by business. Rehabilitation clients have often been trained in outmoded skills.

- The rehabilitation counselors have not known how to approach business people and often look at the business person as an adversary.

- The rehabilitation counselors have not been trained in job placement. They don't know how to go about marketing their product — trained disabled people.

- The business person has not fully understood what is involved in bringing the disabled person into the work place, and, therefore, tends to act defensively — seeing only the negative aspects of having a disabled employee.

This paper describes an approach to rehabilitation that overcomes these problems, and describes one particular program that implements the approach.

The new approach is to develop a partnership of the business and rehabilitation communities to help meet their complementary needs — that of rehabilitation to obtain jobs

for their disabled clients and of business to obtain qualified, well-trained employees. This partnership concept has been formalized under a Federal Government program called *Projects With Industry*, abbreviated as PWI. At this time there are about 100 PWI projects with over 5,000 business people participating as members of their Business Advisory Councils. There have been over 10,000 placements of disabled people into permanent jobs. PWI projects can be roughly categorized into these three models:

- The *Job Placement Model* seeks immediate, permanent, full time employment for already-qualified disabled people by matching their skills with the needs of local businesses.

- The *Work Adjustment Model* provides temporary work experience for disabled people that, in addition to providing opportunity to develop marketable skills, helps to develop those qualities of attitude and behavior that will be desirable in competitive employment.

- The *Skills Training Model* teaches work-ready disabled people technical skills needed to compete for higher paying jobs.

The common attribute of all of these models is the participation of

business people who provide guidance and leadership to the rehabilitation agencies and disabled people. Another positive attribute to emphasis on job placement as the primary goal of the projects.

PWI is placing disabled people in *actual work settings* provides the best means of evaluating their work abilities; knowledgeable business people are used as a resource to identify available jobs, delineate job qualifications, and design training programs; and the *interaction* between business people and the disabled provides a worthwhile learning experience for each about the other.

During the 60-plus years that formal rehabilitation programs have been in existence, there have been many attempts by competent rehabilitation people to involve people with business experience in the rehabilitation process. Some have been very successful, but all have been limited in scope. The clients of that counselor or office have benefited, but the process has not been expanded and replicated.

There have also been a number of business-initiated efforts to place disabled people. Outstanding among these is a project started by the Florida Restaurant Owners' Association. Unlike most other efforts of this

sort, the Florida project was adapted by the Restaurant Owners' national trade association and has become nationwide in scope. It is now operated as a PWI, falling generally within the skills training model.

A formal PWI, as was stated earlier, is established as a partnership between business and rehabilitation. The prototype of such a partnership was created in the early 1970s when the IBM Corporation joined with the Rehabilitation Services Administration (RSA) (then of the Federal Department of Health, Education, and Welfare) and the then Department of Vocational Rehabilitation of the Commonwealth of Virginia to design, develop, and demonstrate for possible replication in other states a new joint training and placement project to benefit the most severely disabled people. These were envisaged as primarily the wheelchair-bound — quadriplegic, paraplegic, cerebral palsied, and advanced arthritic. With time and subsequent replication, however, the IBM-initiated projects have served persons with a broad spectrum of nonintellectual disabilities, including deafness and blindness.

Computer programing was selected as the vocation objective because it is a profession where intellectual capacity is more important than physical dexterity and mobility. Also, computer programing is ubiquitous; it is used by all industries in all locations. There is a continuing and growing need for computer programers in the United States. Computer programing is an excellent job for the severely disabled since it is a well-paying profession with significant growth opportunities. (A good salary is mandatory for a quadriplegic who has continuous medical requirements that can be extremely costly.) Finally of course, computer programing is a



As in any endeavor, practice makes perfect. Many keyboard hours are needed to master the art.



field that is quite familiar to IBM and is one with which we feel comfortable.

All of the projects which have sprung from this particular model share some common characteristics:

- They are sponsored, funded, and administered by local agencies. At the present time, these include state rehabilitation departments, independent rehabilitation facilities; community colleges; state universities; and, in one case, a private nonprofit corporation established specifically to support a training project.

- They are closely guided and controlled by a Council of Data Processing Managers and Programers who are the persons best qualified to prescribe and monitor the prerequisites for entry into training, the curriculum to be taught, and the training standards to be met.

- The responsibility for graduate placement is shared between the sponsoring agency and the Business Advisory Council (BAC) so that optimum placement is assured and that both parties remain deeply involved throughout the process.

After the demonstration project was established at Virginia's Woodrow Wilson Rehabilitation Center, a second project was started in California at the Center for Independent Living. It was at this San Francisco Bay Area project that the major advantages of a local BAC became evident; until then, it had been assumed that the IBM technical contribution would suffice. The capability and enthusiasm shown by the local business community made it clear that BAC was the way to go. This fitted in very well with the initial and continuing concept — to establish programs throughout the U.S. in such a way that these programs become self-sustaining under local control.

It was during the period of establishment of the California project that IBM was approached by Mr. Tom Fleming of RSA who proposed a continuing RSA/IBM partnership to ensure the propagation of this new concept. Under this partnership, the two projects initially started by IBM have grown to 20 projects distributed across the country. More are in process of development.

With succeeding projects came more lessons with resulting procedural changes. In 1976, a project was established within a university — the University of Pennsylvania in Philadelphia. This demonstrated that a third partner could not only contribute but could take a leadership role, still under the guidance of a concerned BAC.

Other projects have been established at the University of Missouri, at Louisiana State University, and at Kent State University in Ohio. Universities that have a strong contributing role include Yale in Connecticut, the University of Alabama at Birmingham, and the University of Maine. In Maine, the project is conducted by the Bangor Community College which is an element of the University of Maine at Orono. The Colorado project is conducted by the Community College of Denver.

Within the last 2 to 3 years, a new project has been developed which has some distinct differences in organization and support as compared to its predecessors. After the project run by Easter Seal-Goodwill Industries in New Haven, Connecticut had been in operation for several years in a very successful manner, some of the BAC members decided to incorporate separately and establish a new project in another city (Stamford) which would be controlled and supported directly by the business community. To this end, they obtained monetary

contributions from potential employers of project graduates, hired the necessary staff, and rented space for training. There are those who predict that just this sort of direct business participation in the rehabilitation process will be necessary to compensate for the expected losses in government support.

In 1978, these IBM-initiated projects formed a national association — the Association of Rehabilitation Projects in Data Processing (ARP-DP). This association has incorporated and accepts for membership any nonprofit training organization whose objective is to train and place severely disabled people as computer programers.

Whereas, in the beginning, IBM's participation was quite comprehensive and in depth, its role now is primarily that of a catalyst. Help is provided at the start and to establish a working BAC, followed by only that subsequent help which is wanted and needed.

The first step is to explain the project's potential to the rehabilitation directors. If they wish to establish a project, and are prepared to support it financially, IBM then works with designated project directors to determine the best training locations, the training agencies, and initial project organizations. The project directors then initiate client surveys and recruitment efforts, while the IBM consultant makes the necessary contacts to establish embryo BACs.

With BAC establishment and its organization into committees, the real work begins. Usually a *Selection and Prerequisites Committee* begins immediately to survey the local data processing community to determine the locally acceptable criteria for student selection. Typically, such criteria include an above-average learning ability, high reading comprehension



Photos on this and page four are from the Projects With Industry project operated at the Long Island, N.Y., Abilities Center. Computer theory and operations are thoroughly discussed (above) in classroom (note interpreter for deaf students). Individual attention (right) irons out student problems, as is also the case on the actual console in the lower photo on page 4. Also on page 4 (top photo), not quadriplegic's (1st row, 2nd person) use of hand-held wands to work the computer console.



scores, and at least an average aptitude for programming — all measured by standard test instruments. Beyond that, in the individual case, they will wish to examine the type of disability, the demonstrated motivation of the potential student, and his recorded education level and record of performance. Some BAC selection committees participate in preselection interviews while others prefer to merely direct the process.

At the same time, the *Curriculum Committee* surveys the data processing community to determine the subject matter and the depth to which it must be taught to meet the local community's needs. These vary in detail because of differences in classes and manufacturers of computers among different areas. The curriculum typically fills a 9 to 10 month period made up of 6 to 8 hour working days and includes a 6 to 8 week period of internship during which the student actually works as a programmer in a data processing department.

The early employment of an instructor allows him to work with the BAC committee in curriculum development. Usually about 6 to 9 months is spent in the preliminaries before training actually starts.

Another essential preparation element is communication with ongoing projects. The existing projects, individually and through ARPDP, are a source of invaluable information for the developing project. This communication is cultivated by the IBM consultant or liaison.

Once training is in process, another BAC committee becomes active — *Evaluation and/or Technical Review*. Through this committee, the BAC periodically meets with each student to become acquainted, review his academic progress, identify problem areas, and evaluate the curriculum and course as a whole. In addition to

the very necessary evaluations already listed, this process provides other, even more valuable, benefits. It exposes the student repetitively to data processing people in a pseudo-management role; the course graduate learns how to present his work and how to answer questions. Even more significantly, the involved managers become comfortable with people with various disabilities; they begin to see the person, not the disability. The members of the evaluation team, having become familiar with certain students and their capabilities, are in a good position to evaluate students for employment in their own companies, can honestly write "business references" for the students, and, can make contacts and open doors leading to interviews and possible employment.

Toward the end of training, the *BAC Placement Committee* becomes more active since it must help train the students in job search and retention, help train the project director and rehabilitation counselors in placement techniques, and take specific action to aid in placement.

In an operating project, all functions are simultaneous. As one class begins, recruitment and selection for the next class starts. The curriculum is constantly reviewed to keep it in tune with local requirements and to ensure that the latest texts and techniques are used. Evaluation is ongoing. And the placement activity includes job development in advance of placement, and usually the recruitment of new BAC members to ensure broad community involvement.

The rehabilitation agency, usually through the project director, is responsible for the identification and provision of all necessary aids, assistance, and training (except for technical training) to ensure that the

student at graduation will be ready and able to go to work, to meet normal work standards, and to compete on a realistic basis with the other programmers. These aids and services may include work adjustment; training in the activities of daily living; purchase, modification, and training in the operation of a vehicle; the purchase of clothes. The project director is responsible to ensure that everything has been done at the proper time to meet the objective — a work-ready, technically-qualified graduate.

As of December 31, 1981, there were 20 projects of the sort described above. There are four more in some stage of development and two good prospects who had requested consideration. More than 650 new programmers had graduated and more than 530 had already been placed in competitive, programmer positions. History suggests that more than 550 of these graduates will have actually gone to work, since placement has consistently exceeded 85 percent.

With the increasing scarcity of federal funding, it will become progressively more important that the available funds be expended judiciously. Projects of this sort, although expensive to operate, are an excellent investment, since they result in a high placement rate and financial independence for the successful graduates; and they address the needs of our most severely physically disabled population. Even a rough balance sheet would show that much more money is saved than is spent.

Mr. Kaplan is Manager of the IBM project to train disabled people and Mr. Hammond is a member of the consulting team. The paper is an updated version (through December 1981) of a presentation made at the First International Abilympic Seminar, Tokyo, in October 1981.

Obfuscation is a term that defines the art of utilization of many big words on the pretext that these words are

Language Used or Used Language?

Obfuscation is a term that defines the art of utilization of many big words on the pretext that these words are

In its several years of existence, this column has drawn most of its sustenance from the offal that social scientists have foisted as the suckling pig. Since the pig was well done, we never considered trichinosis as the root-cause of our malady, concluding, rather, that an attack of conscience had made us cry crocodile tears about our treatment of social scientists' writing habits. It bothered us, nevertheless, that the tears were not real. (And why bother having a malady, if the symptoms are illusions?)

Our cure came when we re-reviewed Edwin Newman's book, *Strictly Speaking*. According to his diagnosis, we need not have tears, crocodile or otherwise; for, indeed, the social scientist deserves our continued derision. He had a lot to say about their leadership qualities, a sampling of which is presented here:

"People are forever quoting Benjamin Franklin, coming out of the Constitutional Convention in 1787, being asked what kind of government the Convention was giving the country, and replying, 'A republic — if you can keep it.' We were also given a language, and there is a competition in throwing it away. Business is in the competition and doing nicely. In its favor, however, one must note that business lags far behind the leader in

throwing away the language we were bequeathed. The leader, moving confidently and without strain, is the social sciences. It is in the social sciences that the true language viability destruction-generating capacity lies."

To get even more specific, Newman writes: "It is a world in which things that are good for society are positive externalities and things that are bad are negative externalities, in which unemployment is classified as an adverse social consequence, in which subjects are listed under rubrics rather than headings, rationing becomes end-use allocation, stressful situations arise in the nuclear or matrifocal family, and people in minigroups or, if the shoe fits, maxi-

groups are in a state of cognitive inertia because self-actualization is lacking."

In his opinion, Newman says that "Social science jargon is tempting because it sounds weighty, important, rather like the policeman's 'I observed the perpetrator,' followed, all being well, by 'I apprehended the perpetrator.'"

"A large part of social scientific practice," he says, "consists of taking clear ideas and making them opaque." And he concludes, "I think it may be better to grunt unintelligibly than to use such language, for it is so impersonal and manufactured as to be almost inhuman." That statement should give cause to the reflection that the social sciences' are supposed to study the "human" who is constantly "dehumanized" in references straining to justify "science," so that people become "subjects," "elements," even "correspondence producers!"

If you don't agree with us (or Mr. Newman), you may want to use the Fog Phase Activator that we have provided in the box. Choose one word from each column and you will have an *integrated policy option* that should initiate you into the esoteric realm of the social scientist.

Fog Phase Activator

A	B	C
1. Integrated	1. Management	1. Options
2. Total	2. Organizational	2. Flexibility
3. Systematized	3. Monitored	3. Capability
4. Parallel	4. Reciprocal	4. Mobility
5. Functional	5. Digital	5. Programming
6. Responsive	6. Logistical	6. Concept
7. Optimal	7. Transitional	7. Time-Phase
8. Synchronized	8. Incremental	8. Projection
9. Compatible	9. Third-Generation	9. Hardware
0. Balanced	0. Policy	0. Contingency

Vocational Adjustment In Multiple Sclerosis

Nicholas G. La Rocca, Ph.D.,
and Nancy J. Holland, R.N.

Background

Nature of Multiple Sclerosis

Multiple Sclerosis (M.S.) is an acquired disease, with onset typically in adult life, which destroys myelin in widely distributed areas of the brain and spinal cord.^{1 2} Once contracted, M.S. does not disappear. During the person's lifetime, the disease may remain dormant, producing no new symptoms after the initial attack. More typically, it produces several attacks, often followed by periods of partial or total recovery. In some cases, symptoms gradually get worse without clearly defined attacks. In general, its course is characterized by a slowly progressive worsening of symptoms with the occasional appearance of new symptoms as well.³

Neurons in the central nervous system (CNS) consist of a cell body, branching projections called dendrites, and a long trailing structure known as the axon. Electrical impulses flow between the electrically negative interior of the axon to the electrically positive exterior in a continuous loop. Myelin is a multilayered sheath of protein and fat which is wrapped tightly around the axon, much like a jellyroll. Myelin insulates the axon like the plastic surrounding a telephone wire. Electrical charges cannot pass through myelin. Instead, they become strongly concentrated at strategically located gaps in the myelin called the nodes of Ranvier. Since electrical charges are concentrated at these nodes, the current can effectively travel down the axon from node to node in a step by step fashion.⁴

In M.S. the insulating myelin is partially destroyed. Electrical impulses are allowed to leak out all along the axon, resulting in inefficient or totally absent nerve impulse transmission. During an attack,

myelin becomes inflamed and swells with eventual areas of myelin replaced by scar tissue or plaques that are randomly and widely distributed in the CNS. Once myelin is destroyed, the body does not produce a replacement. Damage is thus permanent.

The Cause

The cause of M.S. remains unknown.⁵ Current theory holds that it is probably caused by a virus. That this virus is probably acquired before the age of 15 is suggested by studies showing that migration after age 15 from an area where M.S. is common to a region where it is rare, does not lower one's chances of getting it.⁶ This "latent virus" remains dormant for 10 to 20 years. Then, in the face of some unknown precipitating event, the virus becomes active, setting off an autoimmune response.⁷ The body's own system of defenses turns against itself, and myelin is destroyed as if it were a foreign substance.

Distribution

Like polio, M.S. was virtually unknown to medicine before the industrial age. Even today, the disease has an affinity for the most technologically advanced and industrialized areas of the world (Northern U.S., Northern Europe, Southern Australia) and is rare in more agricultural regions (Africa, Asia, Latin America). In the U.S., the prevalence of M.S. is 58 per 100,000 population for a total of about 130,000 cases. There are close to 9,000 new U.S. cases every year.

These cases are not uniformly distributed. In New York, M.S. is more than twice as common as it is in Texas (74 V/S 36 per 100,000). In the U.S., 65 percent of those with M.S. are females, and the disease is twice as common among whites as among blacks.⁸

Hispanics born in high risk N.Y. are more likely to get M.S. than their compatriots born in low risk Latin America. However, Asians seem to be at low risk regardless of where they are born.⁹ M.S. is more common in families that have an affected member.¹⁰ However, among identical twin pairs, usually only one of the twins is affected.¹¹ It thus appears that there must be environmental, racial, and familial influences at work in M.S.

Characteristics

The Multiple Sclerosis Comprehensive Care Center (MSCCC) is a multidisciplinary outpatient facility within the Albert Einstein College of Medicine offering continuing care to people with M.S. Over 1,500 people have been seen. Approximately 300 from the center and from three voluntary agencies have been followed longitudinally using a series of periodic interviews and neurological evaluations.¹² Data from these studies have provided information concerning the physical and psychosocial characteristics of a population affected by M.S.

The MSCCC sample is 74 percent female and 26 percent male. The average age of onset of symptoms was 30. For 70 percent, symptoms began between the ages of 20 and 40, the prime years of advanced education, career development, and family life.

In M.S., neurological symptoms result from swelling and edema in the CNS and from a decrease in nerve conduction. The patients in the MSCCC study had the disease an average of 13 years. The most common symptoms were: difficulty walking (88 percent), weakness (69 percent), urinary problems (63 percent), clumsiness or tremors (61 percent), and numbness (53 percent). Less

common symptoms were visual problems (45 percent), pain (39 percent), speech difficulties (34 percent), dizziness (28 percent), and difficulty in intellectual functioning (16 percent).

In everyday terms, these symptoms may imply problems in traveling to work; lack of endurance due to easy fatigability; disruption in sexual response; loss of some degree of independence; and changes in family, career, or social activities. Its effects are long term since the average life expectancy at onset is 35 years.¹³ The effects are also broad and strike at a critical time of life. The course is variable and unpredictable. Prognosis is usually impossible to determine early in the illness. There is no known cure or prophylaxis and nothing currently known will slow or halt the progression of the disease or influence its course.

Vocational Disability

What does this seemingly gloomy picture imply for employment? Work represents the largest, single commitment of one's time and an important component of the self-image. Work also contributes to national resources and to family financial stability.

In the MSCCC study, the ages of those interviewed ranged from 18 to 72 with an average of 43 years. In the general population, 81 percent of the males and 50 percent of the females in this age range are employed. In the MSCCC sample, the figures were 34 percent males, 20 percent females, and 24 percent for both sexes combined. In other studies, employment has ranged from 20 percent^{14 15} to 30 percent.^{16 17 18}

Do these figures represent unemployment or indicate underemployment? Are the 76 percent unemployed in the MSCCC groups too disabled to work or are their skills often underused by the

economy? Several facts suggest underemployment. Ninety-five percent of the people interviewed by the MSCCC had been employed at some time. They had an average of 13 years of education. Sixty percent were able to walk without aids, and only 17 percent were confined to a wheelchair.

The unemployed had been out of work an average of 9 years. Close to 44 percent had left work due to M.S., often because of physical problems. Those still employed had missed work an average of only 5 days. Forty percent were interested in new employment, while 34 percent felt they needed some sort of work preparation.

In a multivariate analysis reported elsewhere,¹⁸ we examined the influence of several factors on employment status. We found that older, better educated, and less neurologically impaired males were most likely to be employed. However, neurological impairment only accounted for some of the differences seen in employment status. Some severely impaired patients were employed full time in positions of considerable responsibility, while many minimally impaired people were unemployed. Neurological effects, apparently, do not even begin to explain the high unemployment rate in this population. Many are unemployed even though they are physically, mentally, and educationally capable of holding a job. This presents medicine, rehabilitation, and society itself with a challenge. How can underemployment be dealt with so that those who would like to work are kept on the job or returned to employment?

Comprehensive Care

In August 1981, the MSCCC completed a demonstration project for vocational rehabilitation of people

with multiple sclerosis, with the support of a grant from the Rehabilitation Services Administration (RSA). The effort reflected a nationwide need for developing vocational potential. The concept was formalized by agreement between the National Multiple Sclerosis Society (NMSS), RSA, and state vocational rehabilitation agencies in 1977.

The demonstration project included the following objectives: establish a network with government and community agencies to provide supportive services to the M.S. vocational rehabilitant; educate vocational rehabilitation professionals, particularly within the state systems, to the potential and problems of M.S. people; educate health professionals about the vocational potential of M.S. people and encourage their early referral; establish a prevocational workshop to meet the special needs of M.S. vocational candidates; and provide comprehensive medical services to prevent and/or treat potentially disabling symptoms, recommend adaptive devices and techniques, and promote psychosocial adjustment.

Establishing A Network

The initial step was contact with key personnel in those agencies identified as important resources for the M.S. person, including state office divisions of vocational rehabilitation, visiting nurse associations, rehabilitation facilities, and local chapters of the NMSS. These contacts facilitated the referral process, and supported subsequent education efforts.

Education Of VR Professionals

This was accomplished by several all-day workshops, sponsored by the MSCCC, for the administrators and supervisors of resource agencies to discuss the problems and potential of

M.S. people. This promoted an atmosphere of interest and concern at the agencies, although directly reaching a limited number of personnel from each facility. Subsequently, MSCCC staff visited each agency for lecture/discussion sessions with the entire staff. This grassroots feature was crucial, since initial decisions for acceptance or rejection of the M.S. applicant are made by staff, rather than supervisors or administrators.

Educating Health Professionals

This large and varied group was approached through publications in professional journals, *e.g.*, *New York State Journal of Medicine*, *American Rehabilitation*, and speaking appearances by center staff at conferences of professional associations, primarily physician and nurse groups.

Establishing A Prevocational Workshop

This was organized at the MSCCC, with clients selected from people known to the MSCCC. The project was phased out as similar programs in the community became receptive to working with M.S. clients, providing the necessary modifications in evaluation procedures and in techniques to develop work readiness. Our conclusion is that many existing programs can serve the M.S. population, given staff understanding of the disease process and implications, and with minor modifications of standard procedures.

Providing Comprehensive Medical Services

This component of the demonstration project allowed for expansion of existing services to reach more people. The philosophy of comprehensive care at the MSCCC predated the RSA project and provided the stimulus for pursuing voca-

tional rehabilitation, since a gap in this area presented an ongoing problem.

Characteristics of M.S. And Their Management

Several factors support the need for vocational rehabilitation. Onset of symptoms occurs in young adulthood. The disease, therefore, has long term (even lifelong) consequences. Young adult spouses, small children, perhaps siblings in the household, all are deeply affected by the role that the M.S. person maintains or assumes. Continued productivity and status within the family certainly ease the adjustment of other family members.

Disease-related characteristics which most often interfere with vocational pursuits include: unpredictability of the disease course, easy fatigability, mobility impairment, visual disturbances, and bladder dysfunction.

Unpredictability of the disease course seems to be a greater factor in maintaining unemployment than in precipitating it. Once a person is receiving disability and other benefits, the response, "Suppose I get worse" often accompanies resistance to vocational rehabilitation. Counseling may be helpful. From a statistical viewpoint, most people with M.S. do not become severely disabled. This was identified as early as 1969 in a Mayo Clinic Study of people with M.S. in the Rochester area. Keeping in mind that interference with mobility is a major cause of M.S. related impairment, the Mayo study found 85 percent ambulatory after 10 years, and 74 percent ambulatory after 20 years.¹⁹ The realistic basis for optimism needs to be stressed, not only for the person with M.S., but for all health and vocational professionals who deal with the M.S. client and family.

Easy fatigability can be counteracted by various measures. Relief of muscle stiffness (spasticity) in the legs will reduce fatigue in some cases. Nonamphetamine energizers, e.g., Cylert^(R), may increase the fatigue threshold, and appropriate mobility aids — short leg brace, walker, etc. — can diminish the degree of fatigue. Use of a motorized scooter-type vehicle (Amigo^(R)) not only conserves energy but also has the appeal of lacking "handicapped" associations. These scooters are attractive and "sporty" looking and conserve the energy ordinarily used to propel a wheelchair.

Visual disturbances are usually transient, but, following an acute visual problem, such as blurred or double vision, or a "blind spot" in the central vision, some residual deficit may remain. There is often a delayed pupillary response, which is manifested by intolerance for bright or fluorescent lights. Use of sun-sensor lenses (polaroid type) relieves the need for the eye to respond rapidly to changes in light intensity or to tolerate bright light for long periods. More severe visual problems require those adaptive measures normally employed for individuals with defective vision.

Bladder dysfunction occurs at some time during the disease course in the majority of M.S. people.²⁰ Symptoms may be very distressing and confine the person to home or to short excursions with a toilet always near by. The need to urinate frequently and with short notice is often accompanied by episodes of complete loss of urinary control. The realistic fear of wetting oneself in public impedes social interaction and vocational pursuits. Bladder symptoms respond well to medical management, but require the expertise of a clinician knowledgeable in the area of M.S.

neurogenic bladder dysfunction.

Importance Of Medical Care

The preceding description of symptom groups and their management, provides a background for expansion of the concept of comprehensive medical care as a component of prevocational and ongoing vocational adjustment. This model focuses on all the health and adaptation needs of the person with M.S. and family: medical interventions, rehabilitative techniques, adaptive devices and procedures, and psychosocial adjustment.

It is important to initiate medical management before a vocational rehabilitation program is started. The handicapping symptoms can interfere with pursuing a vocational program, in both the evaluation and training areas. Failure at this point further damages self-esteem and will discourage subsequent attempts by both the person and the sponsoring agency. However, when the person experiences some degree of symptom relief or increased independence in daily activities, a more optimistic attitude toward reaching vocational goals can be expected. Another vital point is that it is easier to maintain a person in education/vocational pursuits than to resume these activities once inactivity has become a way of life. This underscores the need for health and VR professionals to address vocational issues with the M.S. person who is currently a successful student or gainfully employed. Potential obstacles can be identified and planned for.

A case example is a young woman who was doing well in her college preparation for a career as a horticulturist. This involved many hours in the greenhouse, as would the resultant career. Since people with M.S. eventually experience a temporary

worsening of symptoms when exposed to heat and humidity, this young woman needed to change her educational program and occupational plans. She has since received her masters degree in social work, and is now employed as a hospital social worker.

Several teachers who were ready to leave work because of tremendous fatigue, have continued in their jobs by trading canes and lofstrand crutches for Amigos^(R). The enormous energy expended in struggling to walk was conserved by using these motorized vehicles. Some modification was needed by the involved schools as well, such as arranging for classes to be held on a single floor, when no elevator was present. The school administration was mandated to assist with these modifications by the Rehabilitation Act of 1973.

Yet, another young woman was about to leave her job in data processing because of urinary symptoms — urgency, frequency, and loss of urinary control. Following measures to diagnose the exact nature of the neurogenic bladder problem, medication and intermittent self catheterization controlled all of the distressing and, in this situation, handicapping, urinary symptoms.

Psycho-Social Adjustment

Our experience at the MSCCC has included a major effort in psychosocial adjustment over the last 5 years, including individual, couple, family, and group counselling. The orientation was usually general adaptation to M.S., with the focus on resolution of the person's internal conflicts, improved interpersonal relationships, and deciding and meeting vocational goals.

The group format has been an effective way of working towards these goals, since cohesion readily emerges

from the shared experience of M.S. Support and feedback, with professional guidance seem to enhance self-esteem, highlight positive and negative areas of inter-personal relations, and clarify vocational goals. The painful acknowledgment of limitations, with exploration of possible career alternatives, is encouraged. Successes and failures during this process are talked about, explored and used to advance towards an optimal, adaptive situation.

Dr. La Rocca and Ms. Holland are both staff members of the Albert Einstein College of Medicine. The project described is supported by grants from the National Multiple Sclerosis Society, the Rehabilitation Services Administration, and the National Institute of Handicapped Research.

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(Continued on Cover III.)

PUBLICATIONS & FILMS

Working: Changes And Choices; Article Booklet; Study Guide. 528 pages \$12.95; 48 pages, \$4.95; 64 pages, \$4.95, respectively. Human Sciences Press, Inc., 72 Fifth Avenue, New York, N.Y. 10011.

This anthology brings together the latest thinking of a broad range of experts on the world of work. They assess changes occurring in the nature of work and workers and discuss critical choices about work faced by Americans individually and as a society.

This collection is one of three components originally designed for Courses by Newspaper, a national education program administered by University Extension at the University of California, San Diego and funded by the National Endowment for the Humanities.

The *Article Booklet* consists of 15 articles written for Courses by Newspaper and published in the nation's newspapers in the fall of 1981.

The *Study Guide* integrates the articles that had appeared in newspapers and the anthology articles to help students understand the full range of complexities and issues surrounding work and working. Each of the five major parts features learning objectives, an overview of the readings, discussions of key concepts and definitions, and both factual and essay/discussion questions.

The Meaning of Human Suffering. Flavian Dougherty, C.P., editor. Human Sciences Press, 72 Fifth Avenue, New York, New York, 10011. \$29.95. 349 pages.

Clergy and human service professionals address the fundamental problem of suffering from philosophical, theological, and existential per-

spectives. Based on the First International Ecumenical Congress on the Meaning of Human Suffering held at Notre Dame University, the book investigates historical as well as contemporary attitudes toward this perennial and topical issue. Throughout the essays, serious consideration is given to the key question of how to reconcile suffering with the Christian belief in a God of love.

In its eclectic approach to the meaning of suffering, the book examines the contrast between Freudian and Marxist theories and Christian beliefs; a comparison of Buddhist and Christian approaches to the transcendence of suffering; the violence and strife which has characterized the long history of Israel; and the New Testament's teachings on suffering, particularly as reflected in the passion and death of Christ.

Changing Government Policies For The Mentally Disabled. Joseph J. Bevilacqua, editor. Ballinger Publishing Company, Box 281, 54 Church Street, Harvard Square, Cambridge, Massachusetts 02138. 320 pages. \$28.50, hardcover.

Significant legislative gains for the mentally disabled were made in the 1970s. Unfortunately they did not represent a single, coherent policy; rather, they were an unfocused potpourri of allocations influenced by various political and economic pressures, special interest groups, professional practitioners, and federal, state, and local planning and regulatory bureaucracies.

Concerned professionals met to assess these policy patterns and to identify courses of action. The results of that conference are available in this volume. *Changing Government Poli-*

cies for the Mentally Disabled analyzes the forces that influence the direction of public services for mentally disabled citizens. The contributors examine the critical funding, regulatory, advocacy and professional issues that influence the formulation of policies designed to help the mentally ill live as independently as possible. Their analysis points to pivotal questions that embrace all human services—questions painfully relevant in this era of federal austerity. The policy options discussed constitute a foundation for the development of a more flexible and responsive service system.

This national conference—the first of its kind—honored the late Congressman John Fogarty, whose work in the early 1960s charted much of our national health policy.

Training The Mentally Handicapped For Employment. Richard T. Connis, Jo-Ann Sowers, and Linda E. Thompson, editors. Human Sciences Press, Inc., 72 Fifth Avenue, New York, N.Y. 10011. 192 pages. \$18.95.

Recent developments in vocational training have clearly demonstrated that the mentally handicapped can be trained to perform relatively complex work skills through the application of systematic teaching procedures.

Designed as a practical training manual, this work provides a detailed description of effective methods to train mentally handicapped people for competitive employment. Based on a highly successful habilitation project, the Food Service Vocational Program at the University of Washington, the book contains concrete information on specific training techniques, treatment interventions in the work setting, job placement strategies, and followup techniques. In addition, administrative and evaluative skills, funding dynamics, and data collection systems are carefully examined.

The procedures described are primarily based on behavior modification techniques. The authors delineate specific skills needed by the program's clients, and details the systematic training and evaluation components that are inherent to behavioral approaches. Professionals in special education, teachers, administrators, and all medical and mental health practitioners working with the mentally handicapped should value this comprehensive guide to vocational education and training.

Four publications. Institute for Information Studies, 200 Little Falls Street, Suite 104, Falls Church, Virginia 22046.

Intimacy and Disability. Written by disabled experts in the fields of sex education and disability, this guide discusses many disability-related issues that can affect the intimate relationships of disabled people and suggests coping strategies for effectively dealing with them. Emphasizing the importance of the total relationship between partners, the authors have included discussions of: self-image, body image, prospective partners, different types of intimate relationships, reproductive health care, sexual options, and birth control. (90 pp.; \$6.)

Rehabilitation Engineering Sourcebook — Supplement II. The third and final volume in a series, this publication provides information on assistive devices for persons with sensory and mobility limitations to rehabilitation professionals and rehabilitation engineers. With 100 assistive devices identified for use with specific disabilities, it offers many new and affordable options to disabled people. (80 pp.; \$5.)

Small Business Enterprises for Workers With Disabilities. Citing

case studies of successful disabled entrepreneurs, the author presents a convincing case for small business as a viable career option for some disabled people. This practical and informative book advises potential entrepreneurs with disabilities on topics that include how to: make the entrepreneurial decision, write a business plan, and identify and fund a suitable new business. In addition, it lists private and public organizations which offer financial and/or technical assistance to small business owners. (120 pp.; \$5.)

Social Relationships and Interpersonal Skills: A Guide for People With Sensory and Physical Limitations. Developing successful ways to initiate and maintain social relationships is especially important to disabled people who often contend with negative stereotypes of disability when establishing relationships. This self-help booklet offers readers suggestions on: asserting oneself, confronting others, maximizing physical attractiveness, acknowledging disability, developing disability-specific social skills, and developing different types of relationships. (60 pp.; \$5.)

Mossman's A Problem-Oriented Approach To Stroke Rehabilitation. Second Edition. John W. Sharpless, M.D. Charles C Thomas, 2600 South First Street, Springfield, Illinois 62717. Cloth, \$39.75; Paper, \$32.50.

Doctor Philip Mossman authored the first edition of this book which is revised now by Dr. Sharpless.

From the introduction: "Many publications exist that outline comprehensive stroke management. However, virtually all are organized into sections describing the appropriate roles, activities, and approaches of each health care discipline that may be involved in the patient's management. Such a format

presents two potential problems. First, different institutions may have widely varying availability of staff, and so if all the patient's problems are to be met, staff roles will of necessity vary from one setting to another. Second, organizing the text by health worker discipline tends to identify certain problems as the exclusive responsibility of one or another rehabilitation discipline. Such an approach risks fragmentation of patient care.

This monograph will approach hemiplegic management by focusing on the most commonly observed patient problems. Because the patient carries his problems with him all the time, each health worker will be confronted by each of these problems, even if many are not the primary responsibility of that worker."

Although it can be considered essentially a text on medical management from stroke survival (acute medical management) to discharge, the book does consider, in its later chapters, vocational and social aspects of the stroke patient. The book is profusely illustrated with photographs and drawings.

You Can. 16mm, color, 28 mins., 1980. Produced by KIM Associates and distributed by Mrs. G. Weston, Motion Picture Service, NOAA, Public Affairs, 11400 Rockville Pike, Rockville, MD. 20852.

Depicts a marine science program for physically disabled students held one summer at Wallops Island off the coast of Virginia. Twenty-one students, blind, deaf, and orthopedically impaired, come from around the nation to collect specimens, survey coastline, make geological assessments, and conduct various projects in lab and field. Shows that there is no reason physical disability should bar a student from going into marine science.

Notes on the margin...

POST-POLIO STUDY

The Roosevelt Warm Springs Institute for Rehabilitation is conducting a survey of persons who are post-polio in order to discover the long term effects of polio. It is generally believed in the disabled community that polio has ongoing and long term effects such as increasing muscular weakness and joint pain.

This study will try to determine the presence and nature of long term effects and any corelation such effects may have to employment, support groups, equipment use, age, and other items. You are encouraged to request a copy of the survey from the Institute because this study could lead to superior treatment for persons who are post-polio. Ann Bailey, M.D., Roosevelt Warm Springs Institute for Rehabilitation, Warm Springs, Georgia 31830.

MEETINGS, COURSES, ETC.

. "Prenatal and Perinatal Factors Relevant To Learning Disabilities" 20th International Conference. Washington Hilton Hotel, D.C., February 15-16, 1983. For more information: Association for Children and Adults with Learning Disabilities, 4156 Library Place, Pittsburgh, PA 15234.

. 5th annual International Abilities Unlimited Exposition and Job Fair for the Handicapped. April 21-24, Anaheim Convention Center. For more information: I.A.U.E., 2945 Harding Street, Suite 107, Carlsbad, California 92008.

. 1983 National Conference of the National Industries for the Severely Handicapped, Inc. Sheraton World, Orlando, Florida, April 24-27, 1983. Further information: Trudy Brisendine, Director of Program Services, NISH, 4350 East West Highway, Suite 1120, Bethesda, Maryland 20814.

. One-week courses:

Cross country skiing/pulking - Jan. 9-14.

Cross country skiing/pulking - Feb 6-11.

Alpine skiing/pulking - Feb. 13-18.

Weight training & swimming - Apr. 3-8.

Archery and boating - May 8-11.

Professional development workshops and two, three, and four week courses are also available. For further information: Vinland National Center, 3675 Ihduhapi Road, Loretto, Minnesota 55357.

POSTER AVAILABLE

The image of disabled people making valuable contributions to society is promoted in a new poster series from the Independent Living Research Utilization project of Houston.

Entitled "America Needs All Its Citizens" the poster series is designed to dispell the low expectations that the general public has of people with severe disabilities. To do this, the posters depict disabled people in roles and activities typically considered possible only for able-bodied people. They are shown as capable of self-determination and of contributing to their communities.

The first poster in the series, a man in an electric wheelchair working at a construction site, has been completed and is available for purchase. Others are being planned.

To order the first poster, send your name, address, and a check or money order for \$5 per poster to ILRU, P.O. Box 20095, Houston, Texas 77225.

GUIDE TO 504

Mainstream, Inc. introduces a guide for hospitals and health professionals on providing health care and employment to disabled people. "A Hospital Guide To Section 504" is a comprehensive guide to the federal regulations and issues involved in serving the disabled community.

It is available for \$37.50 from Mainstream, Inc., 1200 15th Street, N.W., Washington, D.C. 20005.

REPORT RESOURCES

INTERNATIONAL DIRECTORY OF ACCESS GUIDES. Rehabilitation International U.S.A., 20 West 40th Street, New York, N.Y. 10018.

EXPERIMENTING WITH SOCIAL CHANGE. An interpretive history of the southern Alberta COMSERV project. National Institute on Mental Retardation, Kinsmen NIMR Building, York University Campus, 4700 Keele Street, Downsview (Toronto), Ontario, Canada M3J 1P3. \$10.50.

1979-1981 Biennial Report HUMAN RESOURCES AGENCIES. Programs, needs, goals. Office of Financial Management, House Office Building, Olympia, Washington 98504.

REHABFILM NEWSLETTER. The quarterly magazine devoted to audiovisual materials relating to disabled people. Circulation Department/RW63, Rehabfilm Newsletter, 20 West 40th Street, New York, N.Y. 10018. \$10.00 per year in North America (\$15 elsewhere).

NIMR PUBLICATIONS 1982. The National Institute on Mental Retardation, The Canadian Association for the Mentally Retarded, Kinsmen Building, York University Campus, 4700 Keele Street, Downsview, Ontario, Canada M3J 1P3.

BRAILLE BOOK REVIEW. (bimonthly) Talking Book Topics, CMLS, P.O. Box 30022, Tampa, Florida 33630.

A SOURCE BOOK. A catalog of training programs, publications, resources, and ideas of fundraising and management from the Grantsmanship Center. The Grantsmanship Center,

1031 South Grand Avenue, Los Angeles, California 90015.

BREAKING DOWN BARRIERS TO DENTAL CARE. American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611.

NORMALIZATION RE-EXAMINED (Advancing Your Citizenship series) Gilbert Foss, editor. Rehabilitation Research and Training Center in Mental Retardation, University of Oregon, Eugene, OR 97403. \$5.

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SELECTED ASPECTS OF FINANCIAL MANAGEMENT IN REHABILITATION FACILITIES: A RESOURCE MANUAL. Jerome R. Lorenz, Chris S. Graham, Patsy L. Hashey, and Richard J. Baker. Published by the National Association of Rehabilitation Facilities. Available from Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin, Menomonie, WI 54751. \$14. (members); \$18. (nonmembers).

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The Improved Wheel From the Chair





When an institution decides to leave a tree standing and bend a sidewalk around it, one has the feeling that it can be as accommodating for people who have physical limitations.

And when the institution turns out to be the Smithsonian, with its Romanesque castle and museums with marble steps stretching almost out of sight, you know its determination must match its empathy.

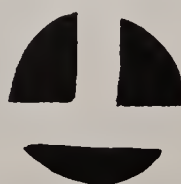
Not only has the Smithsonian Institution set about to make its network of a dozen museums and zoo accessible, in some cases it has designed or adapted exhibits with handicapped people in mind. Its mode of operation and some of the projects could serve as a pattern for the fast-growing museum business.

While the work has been underway for several years, the International Year of Disabled Persons seemed to act as a galvanizer. It was during the past year that the singular Hirshhorn Museum reopened its sculpture gardens, which now has two long, gently graded ramps which make its sunken garden accessible to people who have mobility impairments. A third ramp provides access to the

lower level of the garden. The pathways among the pine and hawthorn and about 75 sculptures have been resurfaced to make them traversable by wheelchairs.

The Hirshhorn has one-hour, sign-language tours on Sunday afternoons featuring the permanent collection of sculptures and paintings and whatever special exhibit is currently on display. The tour is given by a member of the trained docent staff.

Blind persons, if accompanied by sighted companions, are permitted to touch about 30 works by Rodin, Degas, and other major sculptors. These works of art are identified by a symbol on each pedestal.



The Arts and Industries building, second oldest building on the mall, harks back to the 19th century and is the part of the "nation's attic" most devoted to that century. Its 25,000 objects are accessible to people in wheelchairs if they use the west entrance by the Victorian garden.

Next to this building is the castle, itself, with its several turrets and sunshine filtering in through leaves and leaded glass windows. The castle is used for a few choice offices, a resting place for the late James Smithson, and some displays of a regional nature on the first floor. Some plans are being pursued in making the building more accessible. Meanwhile, anyone in a wheelchair, by calling in advance, can be assisted up a steep ramp on the south side.

Next to the castle is the Freer Gallery of Art, seldom crowded but world famous for its Oriental art. Disabled persons who cannot use steps can enter the Freer through the receiving room located at the sidewalk level on the south side. Staff members are available to accompany them on the service elevator to the second floor gallery. Labels on exhibit cases have been lowered.

The National Air and Space Museum, now the most popular museum in Washington, arrived on the scene late enough to be in touch not only with space exploration but with the emerging needs of elderly and disabled people. In this building, people can do everything from touching a moon rock to hearing the thoughts of scientists — through use of a "paperless braille reading machine" — about life in the future.

Both entrances to the building are ramped. Three parking spaces are reserved for handicapped visitors in the commercial garage beneath the museum. Every level of the building can be reached by elevators. Clamp-on mirrors are available to help people with limited head mobility to view exhibits from a wheelchair. Space for three wheelchairs is set aside in the theatre, and the Spacearium will hold about 20 wheelchairs.

A cockpit trainer which gives

visitors a chance at the controls of a simulated airplane is accessible to people in wheelchairs. The museum's brochure has an edition printed in braille and large type as well as a tape-recorded version. Tours of some of the galleries have been recorded on cassettes, and six portable cassette playback machines are available.

There are tours for hearing-impaired visitors, with a TTY enabling them to arrange the tours in advance. There are tours for visually impaired visitors. A list of exhibits tells which items can be examined by touch. Other exhibits are illustrated in booklets of raised line drawings, available at an information desk.

Across the mall, where Constitution Avenue nears the Capitol, is the National Gallery of Art, a bureau of the Smithsonian funded separately by Congress. The West Building (old museum) and East Building (new museum) have elevators at all levels and special drinking fountains, telephone, and restroom facilities. Wheelchairs and routing maps locating the special facilities are available at entrances. As with other museums, there are certain pieces of sculpture which may be touched by people with visual impairments.

West of the art galleries is the National Museum of Natural History/

National Museum of Man, and visitors in wheelchairs use the entrance on Constitution Avenue. All exhibition floors are accessible by elevator. First floor restrooms near the entrance are adapted to the needs of disabled people, and there are lowered telephones and drinking fountains. The snack bar in this museum, as in some of the others, has a self-service food carousel, and people in wheelchairs sometimes need help reaching items in the center.

At the National Museum of American History, ramps lead to an entrance from Madison Drive. Each entrance has electrically-operated doors. All areas are served by elevators, and with a few exceptions the exhibit areas are barrier free. Restrooms on the second floor are partially equipped to accommodate wheelchairs. There is a guide to the museum pointing out features and programs for disabled persons.

Every Sunday, there are sign-language tours of the museum. In one corner there is a permanent, medically oriented exhibit called "Rehabilitation Discovery Corner" depicting the evolution of the wheelchair and the development of prosthetic devices. This museum has had a lecture series concerning famous Americans who were disabled, such as Wiley Post, Harriet Tubman, and Theodore Roosevelt.

At the zoo — or the National Zoological Park — some of the miles of walkways are steep, and the Smithsonian suggests to people with mobility problems that they spread their visit over several days. There are a few parking spaces reserved for handicapped people. All public buildings have an accessible entrance. Restrooms, water fountains, and telephones can be used by people in wheelchairs.

The Anacostia Neighborhood

Museum in southeast Washington, a center for black heritage, is in a converted movie theatre that is accessible to handicapped people.

An historic building which was once used by the U.S. Patent Office now houses the National Portrait Gallery, the National Museum of American Art and the Archives of American Art. There are formidable sets of stairs on two sides of the building, but persons with limited mobility can gain access by using a ramp at 9th and G Streets or through the garage.

The Renwick Gallery occupies another historic building, and at first glance about the only amenity one can see is a curb cut at 17th and Pennsylvania Avenue. By phoning in advance, entrance can be made by hydraulic lift and service elevator on 17th Street.

The National Museum of African Art at 318 A St., N.E., dedicated to the arts of Africa, is housed in a row of nine houses on Capitol Hill which are being made accessible this year. Visitors using wheelchairs can reach the museum's first floor galleries via a rear entrance. Hearing impaired visitors may request sign or oral interpreters for programs and special events at the museum.

The remaining facility is the Cooper-Hewitt Museum in New York city, a museum of design, located in the renovated Andrew Carnegie mansion. There is parking for handicapped visitors and access by ramp to the building.

The world's largest museum complex thus shows how the doors can be opened so that more people see the view from the castle and share the wonders.

Mr. Brubeck, now retired, was a public affairs officer in the Department of Health and Human Services.

A brochure, "A Guide for Disabled Visitors," can be ordered from the Visitor's Information Center, Great Hall, Smithsonian Institution, Washington, D.C. 20560. Inquiries about special programs for disabled persons can be directed to the Smithsonian's Office of Elementary and Secondary Education.

NEWS, NOTES, ANNOUNCEMENTS

Scientists Work On Speech Simulators For Speechless

The revolution of the 1980s which may well put a computer in every home is a promise to some while a threat to just as many others. There are those, however, for whom technological advances offer real hope in the struggle to overcome physical handicaps.

While television's "bionic" men and women are exaggerated for dramatic effect, scientists at research universities throughout the nation are attempting to adapt the computer to the problems of people handicapped because of accident, illness, and nature's mistakes.

At Wayne State University, for example, Carl Friedlander heads a team working on a variety of devices able to provide speech to the speechless.

Dr. Friedlander, a 33-year-old computer scientist, has developed a prosthetic device which enables a voiceless person to substitute an artificial voice for his own. Dr. Friedlander and his staff at the WSU Digital Systems Lab are in the process of customizing the device to meet the needs of Mike Mortell, a 32-year-old computer programmer who, because of cerebral palsy, must depend on a wheelchair for mobility and a variety of devices for speech.

Mortell can make sounds but it is difficult for those not familiar with his speech patterns to understand him. He uses an alphabet board and paper and pencil to help him communicate.

The WSU team has combined a voice synthesizer — a device which

uses 64 basic sounds to form words — with a keyboard, video screen, microprocessor and a set of joysticks on a wheelchair to enable Mortell to speak.

Using the joysticks (because of limited muscle control in his arms and hands) Mortell can move a cursor on the screen and select words and letters which are transferred to an artificial voice box and spoken. The device is able to store common phrases and sentences ("My name is Mike," or "I'd like to go to the bathroom"). While it represents a significant advance to someone who cannot speak, the device, which does not yet have a name, has important limitations.

Dr. Friedlander explains: "This thing is still too slow. Even for someone whose hands can operate a regular keyboard, it's not practical in all situations. In a classroom, for example, the instructor can't hold up the class for the four or five minutes it might take the user to formulate a question. Furthermore, some people don't have enough muscular control to operate joysticks."

To solve some of those problems, the WSU researchers are working on the next generation of artificial speech devices while at the same time trying to improve the device for Mike Mortell. Among the options being tested now are a crude glove device with a series of switches which can be made to activate a voice synthesizer and electromyography. The latter process, still largely theoretical, uses electrical signals generated by muscular activity associated with speech. Picked up by attached or implanted sensors, these signals would activate an artificial speech device. It would thus eliminate any need for

video screens and keyboards.

"What's needed for any of these alternatives is greater public awareness of what can be done to help literally millions of people with the technology available today," says Friedlander. "If you think about it, there are about 100,000 new stroke victims each year. About 2,000 of those lose speech. Then there are accident victims, birth defects, and other illnesses.

"A lot of people need the kind of help that increased research in the area can provide."

Total Hip Joint Replacement Report Now Available

A National Institutes of Health Consensus Development Statement on Total Hip Joint Replacement now may be obtained from the NIH Office for Medical Applications of Research.

The report was prepared by a panel of experts which considered scientific evidence presented at a Consensus Development Conference at the NIH. It contains recommendations and conclusions concerning total hip joint replacement.

At NIH, Consensus Conferences bring together researchers, practicing physicians, representatives of public interest groups, consumers, and others to carry out scientific assessments of drugs, devices, and procedures in an effort to evaluate their safety and effectiveness.

Free, single copies of the Consensus Statement on Total Hip Joint Replacement are available from: Michael J. Bernstein, Office for Medical Applications of Research, Building 1, Room 216, National Institutes of Health, Bethesda, Maryland 20205.

The Learning Disabled Adult: An Administrative Challenge

Dale Brown

Learning disabled clients are new to many vocational rehabilitation professionals. The rehabilitation services system continues its strong tradition of including new disability groups, each controversial at the time of acceptance. Despite diminishing funds and shrinking resources, rehabilitation agencies are determined to serve these people.

This article gives a historical perspective of how learning disability became recognized as a severe disability and received its own code in the record keeping system. Training and research efforts are described and these questions are answered: How are states developing policies to serve these clients? What are the challenges and how are they being met?

History

For a long time, learning disabled clients were served only if the disability was neurological in origin, which was difficult to prove since the "soft neurological signs" relied on for diagnosis often are outgrown. Sometimes, counselors would struggle to prove that a given client had mental retardation or emotional disturbance, so they could get needed help. One creative counselor claimed that a severely dyslexic man was "visually impaired." (He couldn't

read printed matter!) Often, this resulted in clients being treated for the wrong disability. Some states, notably California, Texas, Arizona, Wisconsin, Pennsylvania, and Illinois, began to serve learning disabled clients. But, in most of the country, these potential clients were turned away.

With the large numbers of learning disabled people graduating from high school in the late 70's, awareness within vocational rehabilitation began to grow. In late 1979, the proposed regulations for the 1978 amendments to the 1973 rehabilitation act were published in the *Federal Register*. In these proposed regulations, it was pointed out that a learning disability, in and of itself, was not considered to be a physical or mental disability. However, learning disabled adults would be given a special diagnosis to see if any other disability were present. This was a forward step on the part of the Rehabilitation Services Administration.

In the usual democratic fashion, hearings were held all over the country and letters were requested so that RSA could tap public opinion before finalizing the regulations.

A large proportion of the public comment involved learning disabilities. Over 300 of the letters in-

volved learning disabilities. Learning disabled adults, parents of learning disabled adults, and professionals testified at the public hearings. Many learning disabled adults testified publically for the first time, overcoming their language disorders. In Washington, D.C., 12 of 23 people came specifically to ask RSA to revise its policy to include learning disabilities as a handicap in and of itself. Advocates felt the purpose of the diagnosis should be to establish the person's eligibility into the vocational rehabilitation system, not to search for other disabilities. A large group of consumer advocates met with the commissioner and forcefully pressed their point.

In February 1980, Robert Humphreys, the Commissioner of Rehabilitation, appointed a task force to determine the best way that learning disabled people could be served within the vocational rehabilitation system. Marty Spickler, his Director of the Division of State Program Assistance, was appointed chairperson. Marty had worked with learning disabled people as a school psychologist before entering the Rehabilitation Services Administration. The task force included representatives of the RSA regional offices, the Council on State Ad-

ministrators of Vocational Rehabilitation (CSAVR), learning disabled people, and parents of learning disabled people.

The task force members wanted very much for learning disabled people to be served. But "How"? They were mandated to serve people with physical and mental disabilities. Were learning disabilities physical or mental? Nobody knew for sure. RSA follows a medical model. Were learning disabilities medically recognized?

After much research, it was discovered that the *1980 Diagnostic and Statistical Manual of Mental Disorders* included Specific Learning Disabilities (under the name of Specific Developmental Disorder) as a mental disorder. This book is published by the American Psychiatric Association and is the standard reference manual used by physicians. The 1980 edition of the *International Classification of Diseases* published by the World Health Organization also included specific learning disabilities under the name "Developmental Delay Disorders." A Program Instruction was sent to the states about this in July 1981 (RSA-PI-81-82 July 21).

The task force also faced the charge of developing a definition of learning disabilities for VR program purposes. The meaning of the word learning disabilities has always been controversial, since hundreds of definitions have been developed. But most of them were too inclusive for the vocational rehabilitation system.

The effort was coordinated by Don Snyder, an intern in the Washington Intern Program, who wrote many drafts, checked with members of the task force again and again. Heated discussions were held. The resulting definition is as follows:

"For VR program purposes, individuals who have a disorder in one

or more of the psychological processes involved in understanding, perceiving, or using language or concepts (spoken or written) — a disorder which may manifest itself in problems related to listening, thinking, speaking, reading, writing, spelling, or doing mathematical calculations — would be eligible to receive vocational rehabilitation services if they satisfy the following criteria: (a) Their psychological processing disorder is diagnosed by a licensed physician and/or a licensed or certified psychologist who is skilled in the diagnosis and treatment of such disorders; (b) their disorder results in a substantial handicap to employment; and (c) there is a reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability. Individuals who have learning problems which are caused by visual or hearing impairments, motor handicap, mental retardation, or emotional disturbance may be eligible for vocational rehabilitation services under other disability categories."

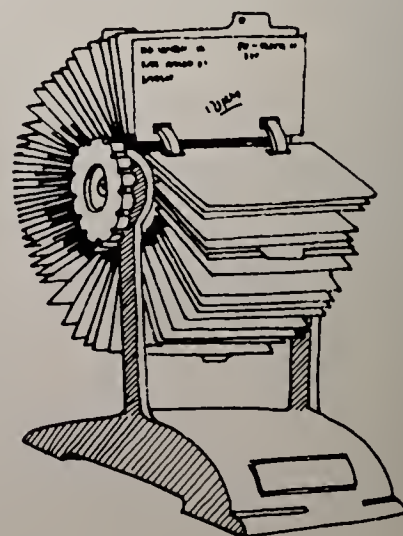
The next issue involved coding the disability. A survey of the states done by CSAVR showed that learning disabled people were served, but were coded in many different ways, such as #699 (other disabling diseases and conditions, not elsewhere classified), code #639 (other disorders of the central nervous system, not elsewhere classified), and code #522 (other character, personality, and behavior disorders). Thus, it was quite impossible to retrieve information on learning disabled clients. The task force recommended that they be coded as a mental disability, allowing a psychologist to be involved in the diagnosis. Code #524 was chosen for learning disabled clients (disorders of specific areas of development not due to another disorder).

The task force recommended that learning disabilities be included as a severe disability in the regulations implementing the 1978 Amendments to the 1973 Rehabilitation Act. This was achieved. Consumer groups that involved learning disabilities lobbied vigorously for it.

An action plan, written by the task force, was approved by the RSA Management Council in October 1980. Most of the items were accomplished, including the definition of learning disabilities and the code #524.

It was suggested that special projects and demonstrations be funded to improve service delivery and knowledge of learning disabled individuals. A grant has been made to a clinic serving learning disabled adults in Pittsburgh, Pennsylvania, a program which combines resources from vocational rehabilitation and the Association for Children and Adults with Learning Disabilities, an organization of parents of learning disabled children.

As recommended in the action plan, National Institute of Handicapped Research designated "learning disabilities" as a research priority. Rehabilitation Services Administration designated Marty Spickler as the central staff person



who would deal with the area. Each region and each state appointed a staff member as a coordinator.

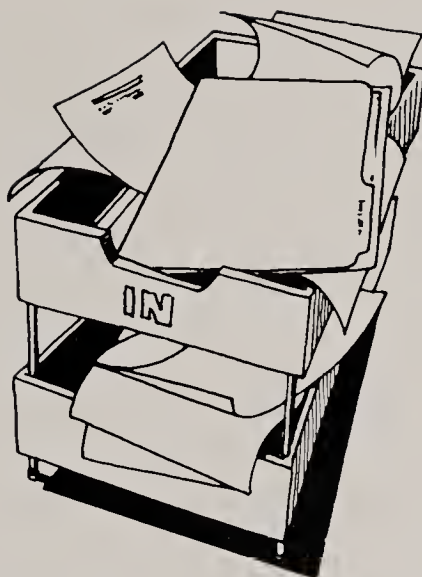
So much interest was generated that the Institute for Rehabilitation Issues chose learning disabilities as one of its three topics in 1982. Experts wrote chapters of a book which will be distributed free to rehabilitation personnel all over the country. A draft was reviewed by over 100 rehabilitation professionals who met in St. Louis to give the authors their comments.¹

Training

The task force realized that training was needed to familiarize rehabilitation personnel with the issue. In July 1981, a national short term training session was held in Denver, Colorado. Each state was asked to send representatives.

Participants came eager to learn and to find answers to their questions and concerns. In a speech to the group, George Conn, Commissioner of Rehabilitation, supported the inclusion of learning disabilities. Participants were taught the federal guidelines and listened to a panel of learning disabled people who discussed their experiences. Experts spoke on definition of learning disabilities, diagnosing the handicap, identifying the vocational handicap, and what ancillary services were available. Edward Pearson, from California and staff from Pennsylvania's Bureau of Vocational Rehabilitation, described their state's pioneering successes. In small groups, participants wrote an Individualized Written Rehabilitation Plan for a fictional "case."

In another small group, participants listed problems they might have in serving learning disabled people. Then they brainstormed solutions. (A major fear was that states



would receive more referrals than they could handle.)

David Roberts, Director of Regional Continuing Education Program VII, summed up well, when he said, "This is no 'end stage renal disease' where there were 50 or 54 served by vocational rehabilitation agencies last year. We are talking about literally millions of people. There's a high potential for a high number of referrals from the estimates people have given us here. We're talking about one or two percent of the United States population that fits into that learning disabled category."

In fact, there has not been a flood of applicants in those states that serve learning disabled clients. When summing up the issues, Marty Spickler explained, "We are not being asked to serve every individual who is labeled learning disabled. Association for Children and Adults with Learning Disabilities speculates that about 3 percent of the adult learning disabled population really needs vocational rehabilitation. In order to be eligible, one must satisfy three criteria for eligibility. The individual must have a physical or mental disability; the disability must pose a significant handicap to employment; and with the

offering of vocational rehabilitation services, the individual's chance of employability would be increased. There are no waivers for any of these three criteria for eligibility in the case of a learning disability referral."

The training program was the beginning step in the process of serving learning disabled people. Peter Griswold, Michigan State VR Director, ended the conference with a summary and recommendations. He suggested that each state develop a "rational operational plan for serving the learning disabled." He also said, "...what we have here is a highly intelligent, highly motivated group of individuals. I am extremely impressed with the attendance here. I have been to many conferences that last more than 2 days and the attrition rate is deplorable. There has been much work here and long periods of time into the evening. Don't leave what you have learned here, here. I would ask you to return to your states and become very active participants, to become, if you will, a change agent. It is a very important task that you have. I would ask you to take that charge, go for it, and do the job."

Program Development In The States

State agencies went to work. According to Marty Spickler, "At this time, all regions have had training and three fourths of the states have had sessions for their staffs regionally and individually." Some states have developed diagnostic tools and criteria to distinguish severely learning disabled people. These clients are being rehabilitated and placed.

Griswold's own state, Michigan, has been working diligently to serve learning disabled people. He delegated the responsibility to Sheryl Avery-Meints, a program development consultant on his staff. She ex-

plained, "It didn't break open for us and the majority of states until LD was accepted as a psychological and mental impairment by the World Health Organization and the *Diagnostic and Statistical Manual III*. Then RSA came out with its Program Instruction to the field telling us this.

"I contacted the Michigan Association for Children and Adults with Learning Disabilities and asked them to assist me in my efforts. I went to the state library, and we just plugged everything into their computer system. I did a search of ERIC and NARIC, using key words like adult, learning disability, learning different. I found very little. I gathered information from other state agencies.

"I began to rewrite our eligibility criteria. Before this was made part of our manual, it received extensive field review from district offices. We chose certain offices with a record for serving learning disabled people and some that did not. We sent it to consumer groups representing learning disabled people in Michigan. Counselors read it to those who couldn't read. Comments were dealt with. That eligibility criteria is now consistent with the state special education eligibility criteria.

"In October 1981, that definition became part of the Michigan policy manual. We disseminated it thoroughly and people were positive. People were encouraged to contact me if there were concerns and questions. I have gotten no negative feedback. None.

"However, many counselors do not have experience in working with LD individuals. There's some fear of the unknown. The typical unknowing approach to LD is 'Oh, No, does this mean I have to teach this person to read? And if the schools couldn't do it, how can I?' Some counselors thought it was a catchall category and

felt anyone could be eligible on the basis of a learning disability. I'd refer them to the manual. The definition is not written to be a catchall. The key is whether or not it's a vocational handicap and if we can provide services that would make the person employable. We haven't been able to train the counselors yet and training is needed."

Sheryl saw two major obstacles for a learning disabled adult desiring services. "We need to develop community resources to serve this population," she explained. "There appears to be no other organization or agency serving learning disabled adults. That means that many LD people are turning to our agency as a last resort. We cannot serve everyone who comes to our agency. We make every effort to refer individuals that we are unable to serve to other community agencies, but there aren't any other agencies."

The other difficulty involved the economy of the Michigan area. "Our unemployment rate is at the 16 to 18 percent level. The majority of LD persons are coming from school and are young and lack work experience. The companies recall their employees and union people after a layoff. It's rare to see a new job listed."

In the last two years, Michigan has lost 110 counselors out of 350. "We have fewer staff serving fewer people," explained Sheryl. To emphasize an LD service system at this point is difficult. At the same time, it's an important group, and we are determined to serve them."

Introducing a new disability area at a time of shrinking budgets and caseloads was an irony noted by many state directors.

Russell Baxter, state Commissioner of Rehabilitation Services for Arkansas, said "Our initial reaction was frustration because of the funding bind. It hit us at a time of a loss in

purchasing power, also a loss of federal social security dollars. The first reaction from counselors was 'Here we go. Less purchasing power and more disability groups. Just what we need!' It was hard to overcome, but we did."

On the other hand, he pointed out that the new emphasis on learning disabilities could be cost effective, when the client received a correct diagnosis. Then the counselor could work with the client to develop an effective IWRP. "Before, the counselor's efforts to work with a client on a rehab plan were trial and error almost."

Patricia Kallsen, state director of Wisconsin Division of Vocational Rehabilitation, explained, "When you're in a situation where there are declining revenues, it's important to move quickly. Don't put a lot of barriers for the learning disabled individual. The earlier we start working with a client, the less expensive it is. Get them at the first job failure. Come up with a successful placement. Don't make them come back 10, 15 or 20 times."

Another area where knowledge of learning disabilities can save money and prevent vocational failure is where people who have other disabilities are failing for no apparent reason. Peter Griswold explained, "For example, let's say an amputee fails our program. He can't cut it. We don't know why. We might assume that he lacks motivation or initiative when really, the learning disability is the culprit."

Dan Schneider, a planning analyst with the Wisconsin Division of Vocational Rehabilitation, described such a case. A man was injured in a motorcycle accident and lost the use of his right arm. Schneider helped him to get SSDI and began to work with him on his GED in preparation for col-

lege.

"Although testing indicated an above average or superior IQ," Schneider stated, "He experienced tremendous difficulty with academics. His biggest weakness was in math. His formulations worked in jobs where he had to use math, but in the classroom he had problems. He had difficulty where reading was involved. He had difficulty expressing himself in writing, in contrast with his abilities in conversation. He came across as intelligent and thoughtful when he had to speak in front of a group. His social studies teacher was very impressed by him.

"A lot of his academic problems could have been attributed to the fact that he hadn't been in school for a long time. The LD was easy to miss. He got so frustrated, he dropped out of sight for awhile. When he came back, we knew more about learning disabilities. We got him tested at a clinic where they were able to identify the problem as LD and tailor a program for him. He's at a technical school now and doing well."

Many learning disabled rehabilitants are self-referred like this man. With the new awareness of learning disabilities, many people come in after years of vocational failure. The majority of referrals, however, come from school systems who are now graduating many learning disabled students.

Cooperative agreements with school districts can solve many potential difficulties. For example, most schools have diagnosed their students. Sheryl explained, "When we were requesting feedback on our policy, parents told us, 'Our kids have been tested and tested and tested. We don't want them to go through all of that again. The schools have the information. Why don't you just go and get it from them?' So we

get that information from the schools."

On the other hand, school systems are generally quicker to diagnose a student as learning disabled than vocational rehabilitation agencies. It's important to educate the school personnel on appropriate referrals.

Diagnosing a learning disability is always a challenge, but it is particularly hard in rural areas. Dave Roberts explained, "When you get into the Great Plains and Rocky Mountain States, you have a lot of space, probably more cattle than people, and a distinct lack of resources. Just getting a WAIS-R becomes a major task in some areas, let alone any reasonably sophisticated interpretation of them." Obviously, in sparsely populated parts of the country, finding someone who can diagnose a learning disability is even more difficult.

Dan Schneider said that in Wisconsin they have had good luck in locating experts in the schools. "For example, way up there in Northern Wisconsin, we located a teacher who does testing. She's a psychomotrist. She has a master's degree and will probably be our expert there. It's a mistake to think that only Ph.D.'s can be experts. She'll do a super job with the learning disabled."

"The states are gearing up to serve learning disabled people," explained Pete Griswold, who is also serving as President of the Council of State Administrators of Vocational Rehabilitation. "Since it's a new disability to us, the states are developing inservice training programs and developing their capacity to diagnose and counsel learning disabled individuals. Learning disabilities are a priority within our client services committee."

Russell Baxter of Arkansas said, "Our counselors realized pretty

quickly that there were many people who needed the service who wouldn't be served unless we provided it. If our counselors see that they really have a service that won't be provided unless we do it ourselves, they'll really try to do it."

Spickler said, "We moved rapidly when you consider that the Learning Disability Task Force has been operating only since February 1980. Much has been accomplished in that short time. It has taken the education community (and I can say this because my professional career began in the field of education) almost 25 years to begin providing those appropriate educational services that learning disabled children and youth require. Considering the amount of time it has taken in education, the accomplishments of the Learning Disabled Task Force should be a source of encouragement. The people who were against inclusion of the LD clients feared that it would lop up all of the rehab funds. We don't have that kind of resistance anymore. The states are helpful up and down the line."

Dale Brown is a writer for the President's Committee on Employment of The Handicapped.

Reference

1) *Proceedings and Resource Guide: Vocational Rehabilitation of the Learning Disabled Client*, Prepared by Patricia L. Patton, Ed.D., San Diego State University, February, 1982.

For a copy of a resource and training document of specific learning disabilities, send \$4.50 to Douglas Rice, Institute for Rehabilitation Issues, c/o Arkansas Rehabilitation Research and Training Center, PO Box 1358, Hot Springs, Arkansas 71901.

Managing Medical Care For Children With Chronic Disabling Conditions

Paul A. Sommers, Ph.D.

Public Law 94-142¹ has caused extensive pressure to be placed on the development of comprehensive services for special children, and it emphasizes early screening, identification, followup treatment, specialized equipment and/or services. Approximately 15 percent of all school-aged children have problems that need coordinated evaluation and a program that frequently involves medical and related health care service.² With the heavy emphasis on early intervention, many children who formerly slipped by are being identified with special health, developmental, and educational problems. Even before school entry, special learning and developmental programs are screening children for potential problems, *i.e.*, Head Start (where approximately 10 percent of all children must be handicapped or otherwise health im-

paired); developmental disability programs for children ages 0-3; optional public school programs for the 0-3 age group of handicapped; Child Find (a public school program to locate unserved and yet to be found handicapped children); and, parent education programs that help parents identify possible problems with physical, mental, and learning development.^{3 4 5 6}

Most professionals agree that early, comprehensive intervention can diminish the severity of many handicapping conditions and, in some cases, actually prevent them from causing exceptional education needs.^{7 8}

A Comprehensive Child Care Center approach can influence early intervention. Through cooperation with child, family, and community organizations, *i.e.*, school, day care center, residential home, developmental disability program, Head Start, etc., a complete network of services and programs can be coordinated to promote optimum development.^{9 10}

Cost Containment

Reasonable and comprehensive evaluations and treatments are often prohibitive to parents who often have to coordinate services from a variety of different health service centers, *i.e.*, neuropsychology, speech pathology, pediatrics, neurology, psychiatry, occupational and physical therapy, etc. This may include numerous telephone calls and trips to different locations. Additionally, due to the need to coordinate between different service providers, x-rays, blood tests, and other evaluations are duplicated because one agency may believe that its service for the same problem is different from another's (including physician judgment about hyperactivity, minimal brain dysfunc-

tion, and various learning conditions).

A comprehensive child care center approach aims at coordinating all evaluations and followup,¹¹ which eliminates duplication (unless a second opinion is needed or invalid testing is suspected). It also focuses clinical judgment on a plan to help the child and family, teachers, and others cope with the disability. The process is cost effective for the parent and generates new referrals from a host of providers, once its efficiency is understood.

Melding Medicine And Education

Multidisciplinary teams, composed of public school staff from the child's district, evaluate and develop an Individualized Education Program (IEP) for each child having a suspected exceptional educational need, as specified in Public Law 94-142.¹² The IEP describes educational objectives and services to be provided. Multidisciplinary team (M-Team) evaluation means evaluation, by a committee or a group of specialists with certification in the problem area (primarily school personnel, but can include any specialist able to help the child). The M-Team obtains evaluation information on which decisionmaking is based; eligibility and needs are assessed; and an education plan is developed.¹³

The M-Team goal is to describe all aspects of the child's health and learning needs so that a clear-cut intervention program can be activated at school and at home to alleviate or accommodate the handicapping condition while producing an optimum learning. Health related services are required for many of these children, *i.e.*, physical and occupational therapy, speech pathology, neuropsychological testing and counseling,

psychiatric evaluation and treatment, drug therapy (to reduce heightened levels of distractibility and lengthen attention span).¹⁴

The child's public school district is mandated to coordinate comprehensive assessment and program development. The role of health care and its application into the child's learning program is implied rather than being specifically defined by law, necessitating independent action on behalf of the health profession to efficiently and effectively serve the child and family.¹⁵ Once the need for comprehensive health services are recognized, basic guidelines call for centralized coordination and control that monitor quality and continuity of care.

Managing Interdisciplinary Activity

Comprehensive service considers the extent of the child's problem, including health, education, and welfare factors, both in and out of the home.

Regardless of whether service comes from a single practitioner or a major, multispecialty group, a comprehensive child care approach coordinates all service. Once referred, the family (and/or outside referral source if not the family) is relieved of orchestrating appointments; arranging financing; involving personnel (teachers, social workers, etc.); securing lodging; and dispensing with other logistical tasks.

Following an orderly set of appointments, each bit of information is condensed, interpreted, and arranged in a clear report of findings and followup recommendations. Reports are sent to the family and authorized professionals. Visits to the child's home school or other location may be warranted as part of the coordinated followup plan. Similarly,

return appointments to the doctor, telephone calls, and surveys to determine client progress and satisfaction are monitored to maintain proximity control.

Ease of Accessibility. Anyone (not only physicians) should be encouraged to make a referral since current laws, require such referrals. The task is eased through telephone, mail, or personal referrals, and through providing toll free telephone numbers or accepting collect calls. Referrals are directed to a patient coordinator who initiates a complete plan for the child/family.

It is important to collect home and school background information before scheduling appointments. Everyone is talked to who can appraise the child's health and learning status, typically the parents, teacher, school psychologist. The completion of medical and educational history questionnaires; requests for past school, psychological, medical, dental, and other records; and, having both the parents and case coordinator specify in writing what questions they would like answers to, should be routinely considered in preparing for evaluation and program development. Reviewing this information identifies areas in need of evaluation and helps to avoid duplications. A staff member then selects the appointments that meet the child's needs, which are then scheduled by the patient coordinator.

Organization Considerations. Implementing a comprehensive child care center approach requires an adjustment from traditional patterns of health care service delivery. A central coordinator is essential for proximity control that is needed in processing referrals, gathering background information, arranging appointments, and monitoring the evaluation/treatment plans.

Financing patient costs is extremely important. Before attending appointments, all who are concerned should know the approximate cost, and what insurance will cover. Financial plans may need to be developed to help families cover costs. A variety of federal and state agencies require prior authorization before they will help with finances. Usually, professionals are available to help with these matters. Social service workers, credit counselors or financial planners should be involved.

Based upon the child's diagnosis or the family's financial status, one or more "special" interest organizations may be called upon, *i.e.*, Muscular Dystrophy Association; Cystic Fibrosis; March of Dimes; state/regional bureaus of education or health; public health departments; private, county or area social service organizations; public schools, and many others.

A comprehensive child care center program should have an administrative relationship to the executive director or governing body of the agency to insure maximum flexibility and effectiveness. At one time or another, it will be necessary for the center to work with each unit, section or department to carry out service. To accomplish this, maximum visibility and authority is needed. A director recognized as the administrative leader of the comprehensive child care program is essential. Program planning, systems development, and budgeting are included in the administrative position description.

A main consideration is that of linking health care services with the educational system since almost every handicapped child served will be in a specialized school program. The most direct way to accomplish the linkage is to employ a professional educator.

Ideally, this person would have a working relationship of current state, federal, and local laws governing educational practice and services. Adding an educational specialist to the health care staff sets the stage for health and educational interaction. Along with coordinating the health and educational aspects of each child's evaluation and followup treatment plan, the educational specialist participates in staffings to discuss health and educational relationships both at the health service center and in the child's home community (most often in the school). This affords the opportunity to observe the child at work and play, interacting with classmates and for related learning activities.¹⁶ The location of comprehensive child care center offices should consider patient accessibility and convenience. It is important for the users to easily locate the center. If possible, a short tour of the facilities will help the patients acclimate themselves.

A marketing campaign helps make public and professional groups aware of services. Clearly developed brochures, slide/tape presentations, video taped cassettes, other related newsprint and radio and television material must be disseminated to inform primary audiences about the program. In time, an effective program generates referrals.

Supportive outreach marketing techniques to further exemplify the program include direct mail marketing to referral sources; inservice training programs conducted by center staff; and symposiums, workshops, and other topical sessions focusing on high interest concerns in the domain of comprehensive child care center services. These activities will serve to strengthen ties between the health care service organization and referral sources. These activities

can be held either at the center or in community locations.

Assessing Progress. Knowing how to keep patients and increase new referrals is a primary goal of the comprehensive child care center approach.^{17 18} Two main consumer groups deserve consideration: the patient/parent group and the referral source.

When properly implemented, the comprehensive child care center does not offend or threaten other health care providers. Essentially, the type of service is seen as secondary to primary care. Other physicians, educators, and health professionals are encouraged to use the service to augment and support their own evaluation and case planning. Although patients may request that their general medical care be provided through the center (if they live close enough), the center approach is meant to be used as a supportive resource for tertiary care needs. Cases that require coordinated, multispecialty evaluation, program planning, and followup are most appropriate.

The best prevention of patient or referral complaints is a satisfied consumer, as it is also a measure of consumer satisfaction. These groups are systematically asked about their satisfaction with both specific and general aspects of health services received. The information monitors the child's progress and the individual ratings are compiled for group analysis of overall operation. Thus, consumer input into the delivery system is a prerequisite to the improvement of that care. While health care providers often recognize the need to include consumer input in an assessment of how well their services are being provided, they as often fail to conduct evaluations which reflect this element.

Evaluation

These elements should be considered in evaluation of program effects: patient service delivery statistics; resource use; comprehensive care vs. profit; consumer appraisal; outreach activity; and dissemination efforts. The list is not exhaustive. Special organizational interests and federal and/or state regulations may dictate a need to add to, delete, or modify evaluation considerations.

Patient Service Delivery Statistics. By monthly recording of referral pattern information, it is possible to monitor referral numbers from each source. Plotting by region, county, or other geographic parameter gives high and low points of referral activity by location and referral source. Travel distance is important to identify since different evaluation/treatment source. Also this information helps determine specific marketing strategies to boost low points of patient referral or to build new community communication links.

By routinely reviewing the frequency of services, it is possible to maintain a proper staff/patient ratio. Daily charting of service statistics is necessary for an analysis of problems with scheduling patients in those departments which have a potentially high patient volume with low service provider capabilities. This is particularly important when patients come from long distances and need to be seen by many specialists in a short time. Multiple scheduling for the same patient on the same day should be booked far in advance.

Staff production data yields income identity. Profiles of interdisciplinary service provider combinations will evolve in relationship to children presenting with specific diagnostic characteristics. Certain combinations will prove more effective.

tive in treating specific groups of patients. This is extremely important information since the most effective combination will prove more successful at less expense than others requiring more evaluation or the need to be seen by different providers. The collection and analysis of service data leads to an identification of the proper interdisciplinary combinations for maximum service production results.

Resource Use. Traditional health care delivery procedures will be altered. As the system becomes more consumer oriented, it requires more efficiency in service use.

Comprehensive Care vs. Profit. To receive comprehensive services, most patients will travel many miles and generally accept a higher cost.

The center approach stresses a coordinated use of staff and patient time. It centralizes communications and reduces the need for duplicating tests and appointments, thus saving patient costs (in addition to unnecessary travel, lodging, and meal expenses due to multiple trips). It encourages the use of interdisciplinary services rather than requiring one practitioner to provide services for some conditions in which they may have little interest or training.

Charges to the patient for the service initially may appear higher due to the fact that advanced planning in setting up the appointment schedule considers the inclusion of all essential services rather than picking one at a time over many weeks or months. This procedure reduces costs since the need for other health service diminishes while the center's efficiency at serving patients increases. This, in turn, increases revenue by expanding capabilities for processing more patients cost-effectively. The patient/family, referral source, and provider of the health care service all

profit from the program.

Consumer Appraisal. A satisfied customer influences other potential patients toward the same care. By systematically asking patients/families and the referral sources about their satisfaction with the care, it is possible to identify program strengths and weaknesses. Once identified, weaknesses can be corrected or modified. Specifically, patients and referral sources are asked what they expect from the service.

While they are receiving your care, make sure that each of their expectations is addressed either during the evaluations, in staffings following the appointments, in a summary report and letter, or at each of these points. Make sure that a clear, understandable explanation is given for each of their questions. Comprehensive care is attained when each expressed need of the consumer has been met.

Outreach Activity. Unlimited opportunities exist to develop related community programs and research. Medical-education interaction on behalf of exceptional children can be followed from a research perspective throughout the child's school years and into adulthood. Progress can be monitored from both the medical and educational points of view and prospective changes made in either the health and/or educational plans as learning or behavioral problems develop. Children with exceptional conditions of high research importance can be selected for individual study. Experimental programs can be implemented for these children with results being compared and contrasted with age-related peers serving as controls.

The comprehensive child care approach affords the opportunity to become identified as a community "resource center" as well as a health care provider service. Community

service can include the following activities: provide training about children with exceptional needs; sponsor conferences and symposiums (regional, statewide, and national); establish lending libraries; establish a "clearinghouse" of free literature from various organizations; provide a speakers bureau; and establish memorial funds for specific diseases or health impaired children (using the interest from the fund to offset the costs of treatment or care to those children who can't afford it; sponsoring scholarships; purchasing equipment to be used by needy children, etc.).

Dissemination Efforts. Marketing is the task of telling patients/families, referral sources, and other potential users what the service is and how they can access it. Marketing serves to increase a program's visibility.

Techniques for marketing health service include the development and dissemination of pertinent information to selected individuals and groups:

- Brochures and pamphlets describing the center and its various programs and services. Information about referral, appointment coordination, evaluation, and followup procedures should be illustrated. The location, type of facilities and available care, complete with a listing of personnel, are all basic requirements.

- Television, radio, and newsprint resources should be primary recipients for all mailings of brochures, press releases, or printed information on program activities. Due to the community service implications, this form of advertisement is often seen as public service, which infers "no cost" to the program while maintaining high visibility in the public sector.

- Direct mail marketing of brochures and other service informa-

tion is key referral sources on computerized mailing lists. Lists are composed of high percentage or potential referral sources. They should include at least two types of service users: High users—those who want to be kept informed of everything and should be, and low users—those who should want and can benefit from the service, but don't.

- The concept and design of consumer appraisal in the health care delivery system is, in itself, a powerful marketing technique. Traditionally, patients have not been asked to evaluate the quality or completeness of their care, let alone judge the degree of satisfaction they have with the care their physicians and other health care staff provide. To have health care staff ask their patients/families and referral sources how much satisfaction they have with services, encourages a more complete participation of the consumer in their health evaluation and treatment plan development. When the consumers know that they do have a voice in health care planning, and, they know what they say is important, they will help market the service through dialogue with others.

- Slide/tape and video tapes featuring the programs and services are welcomed and often requested at service clubs, churches, schools and other regional, state, and national meetings for both professional and parent groups.

- Graphic exhibits are ideally suited for major statewide and national conferences.

- For children who are in school, one of the most effective marketing procedures involves a visit to the school. A meeting is arranged with the child's parents, teachers, and administration to discuss health care results in light of the child's performance both at home and at school.

This opportunity affords the parents and school personnel to personally know how the health care implications apply to the child's program. This procedure demonstrates a strong interest in the child's welfare that cannot be accomplished in any other manner and typically results in new referrals.

Dr. Sommers is Assistant Administrator, Comprehensive Child Care Center, Gunderson Clinic, Ltd., La Crosse, Wisconsin.

Notes And References

1) Public Law 94-142: Handicapped Children Act of 1975. The law is a wide-sweeping, profound, and complex federal law which mandates a free and appropriate education available to all children from age 3 to age 21 at no cost to their parents. Conditions covered include physical, crippling or orthopedic disability; developmental disability or mental retardation; emotional disturbance; hearing disability; visual disability; learning disability; speech or language disability; and other health impairments that interfere with a child's educational development.

2) Wisconsin Department of Public Instruction: Individual Education Program (IEP) Development Process. Adopted from NASDE Manual entitled "Functions of the Placement Committee, 1976." Title VI-C, Wisconsin Resource Center Project, 1976.

3) National Center for Health Statistics. U.S. Department of Health and Human Services, Washington, D.C. 1978.

4) World Almanac and Book of Facts, 1981. Madison Newspapers, Inc., Madison, Wisconsin.

5) March of Dimes. National Foundation, 1977.

6) Education of the Handicapped,

Vol. 7, No. 14, 7-15, 1981.

7) Tenney, H. K. "Health Service Implications of the Education for All Handicapped Law" *Bureau Memorandum*. Vol. 20, No. 1, 1979.

8) Allen, J. E., Lechuck, L. "A Comprehensive Care Program for Children with Handicaps." *Birth Defects, Reprint Series*. White Plains, N.Y. The National Foundation, March of Dimes, 1-7, 1977.

9) Sommers, P. A., Griesse, G. G. "Medical-Educational Interaction for Exceptional Children." *Wis. Med. J.* Vol. 78, No. 2, 1979.

10) Sommers, P. A. and Fuchs, C. "Pediatric Care for Exceptional Children: An Inferential Procedure Utilizing Consumer Satisfaction Information." *Med. Care*. Vol. 18, No. 6, 1980.

11) Sommers, P. S. "Consumer Satisfaction With Medical Care." *Group Pract J.* Vol. 29, No. 7, 1980.

12) See reference 2).

13) See reference 2).

14) Sommers, P. A. "What Physicians Should Know About Children With Learning Disabilities." *Wis. Med. J.* Vol. 80, No. 8, 1981.

15) Palfrey, J. S., Mervis, R. C., and Butler, J. A. "New Directions in the Evaluation and Education of Handicapped Children." *N. Engl. J. Med.* 15, 298, 1978.

16) Example summary reports developed by an educational specialist which show the interaction of health and educational services are available from the author.

17) Sommers, P. A. and Nycz, G. "Monitoring Consumer Satisfaction with Clinical Services Provided to Exceptional Children." *Am. J. Public Health*. Vol. 68, No. 9, 1978.

18) Sommers, P. A. "Predicting Satisfaction with Medical Services Provided to Handicapped Children. (in press). In a book titled: *The Almanac of Special Education*. 1981.

TOPIC OF STATE

(Continued from page 1.)

tional buildings this summer to provide a warehouse, and a work area for grading, labeling, and packaging.

Trainees at New Hope Center will be seeding the houses. Other jobs for the trainees include the removal of suckers, pruning, harvesting, grading, labeling and packing, mopping and sanitizing. Consideration is being given to hiring senior citizens for weekend work. In addition to providing training opportunities, the greenhouses will generate profit for this east-central Wisconsin facility.

—*DVRNewsletter*, Wisconsin Division of Vocational Rehabilitation.

Wisconsin DVR To Try Volunteers

During the next nine months, new faces will appear in 5-7 DVR field offices. Volunteers will become part of the team effort that makes vocational rehabilitation a reality.

According to Judith Gilles, the person hired to coordinate the DVR volunteer effort, "The volunteers will enable the counselors to do the work they were trained to do, freeing them from routine, time-consuming tasks. We want them to look at their jobs, and decide what parts could be handled by the volunteer." Gilles, who most recently was Volunteer Service Coordinator for Chippewa County, emphasizes that this effort is only to enhance staff efforts, not to replace them.

Field offices will be able to volunteer for the project and within each office, individual counselors may elect to participate in the program. The "carrot" in the program,

says Gilles, is that counselors will have more time to do those parts of their job they enjoy most. Volunteers can perform a wide variety of duties, including: teaching daily living skills, transporting clients, peer counseling, locating housing or needed services, information and referral, homecraft assistance, client followup, and increasing public awareness of the VR program.

The project is being supervised by Dick Kosmo of the Central Office. Ms. Gilles, an LTE, who is working full-time on the project for three months, will work part-time for the remainder of the 12-month effort. The project is jointly funded by DVR and the Department of Health and Social Services.

—*DVRNewsletter*, Wisconsin Division of Vocational Rehabilitation.

Early Involvement Goal Of Cal. Project

Recognizing the importance of getting young people with disabilities into the vocational rehabilitation system early, Field Operations Division (California Department of Rehabilitation) has made increased involvement with secondary schools a major initiative for the new fiscal year. Field offices throughout the state are participating in projects with local secondary schools that establish liaisons and interfaces with special education and vocational education officials in the school districts.

Some examples of these activities are:

- Grant proposal assistance was provided to the Irvine School District by Anaheim staff. Anaheim District also negotiated a Memorandum of Understanding with local E.D.D. offices and Orange Coast College.

- Riverside District is getting involved in a successful Special Ed Project along with E.D.D., Riverside County Schools, and San Bernardino County Schools. This project is considered by many to be a model for such cooperative programs.

- In San Jose, a Memorandum of Understanding has been drawn up for a schools project entitled "Special Education/Vocational Rehabilitation-Making it Work at the Local Level" that will set up working relationships in the school system.

- Pasadena District is setting up a cooperative program with the Pasadena School District patterned after the successful Torrance School Program in L.A. Coastal District.

These and other activities with local school districts will serve to identify more young people with disabilities with vocational potential and move them into the rehab process.

—*Rehab Review*, California Department of Rehabilitation.

MULTIPLE SCLEROSIS

(Continued from page 13.)

18) Towne, A., Rehab insights and outlook. *Rehabilitation Record*, 1970, 11.

19) LaRocca, N., Kalb, R., Kendall, P., & Scheinberg, L., The role of disease and demographic factors in the employment of patients with multiple sclerosis. *Archives of Neurology*, 1982, 39, 256.

20) Roussan, M.S., & Holland, N.J., Neurogenic bladder dysfunction in patients with multiple sclerosis. *Geig M.S. Symposium*, #8, 1981.

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AMERICAN REHABILITATION



**Cord Injury History
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COMMENTARY

. . . On Defining Independent Living

In your May/June 1982 issue of *American Rehabilitation*, I was confused and dismayed by the definitions of successful independent living as described in the article "Learning To Live Independently." The explicit definition of successful completion of the Center for People with Disabilities program is "A person who is both living in an apartment alone or genuinely in control and employed or attending an education or vocational training program." (page 8) A negative and contradicting definition of success is given on page 4: "Those who are not successful return to their family or may move into a group home or other facility providing continuous care." The first definition allows that a student is living independently if he or she is "genuinely in control." This is in direct contradiction to the negative definition which is *solely* based on the *type of space occupied*, not the amount of control exercised by the individual or the quality of life perceived by the person with a disability.

Independent living is a concept of *how, not where* a person lives. I sincerely hope the Center for People with Disabilities will re-look at its criteria for success. I feel the definition as stated in the body of the article is detrimental to furthering a comprehensive view of independent living. Living in a group home or a continuous care facility can provide the least restrictive environment for some people. (See *Options*, by Barry Corbett, page 125 for Judy Gilliam's perspective on living in a nursing home.)

Another distressing implication of this narrow measure of success is the

pejorative attitude expressed toward family members. Some severely disabled persons may freely choose to live with their families for a variety of reasons, i.e. financial. It is the attitude of the family members and the person with a disability which determines whether or not there exists an independent living environment. Not all families desire for their disabled relative to be dependent and controlled. Families, like individuals, often need education and guidance in order to change established attitudes and patterns. **Marguerite J. David, MSW**, School of Social Works, University of Washington.

I appreciate Ms. David's comments, particularly with regard to the role that families can play in assisting disabled persons to live well and achieve some level of independence. It is also true that many persons can achieve their maximum independence in a group home setting. Undoubtedly, some programs are more successful at this than are others and those programs should be applauded.

The program which the Center for People with Disabilities operates serves disabled persons who are motivated to achieve levels of independence which, using Ms. David's concept of least restrictive environment, will allow them to function much more closely to the mainstream. It is so easy for such programs to cop-out on their obligation to assist disabled persons to achieve the maximum level of independence that is possible for them. Our definition is not geared toward defining independence for all people. It rather serves the purpose of keeping us honest and of always maintaining that tension that will draw us toward providing those experiences and that support which students need to actively enter the mainstream.

I recently heard a story taken directly from a blind man who had lost his vision and then lost his job as a machinist. He was given a loom and set up to spin yarn in his home. He was asked to report on his earning from his occupation. When he calculated them he found that he was earning \$3.50 a week. His rehab agency closed his case. He was considered to be a successful placement.

This is not how we operate and our definitions simply have been constructed to assist us to avoid lying to ourselves, to our students, and to the community. I would hope that others would try to establish no-nonsense criteria for program evaluation. Independence does truly exist at different levels for different persons, but that fact should not become an excuse for the failure to provide services that will maximize each disabled person's ability to find in his/her own experience the freedom and dignity that comes from a sense of being one's own person. **Homer Page, Ph.D.**, Chairman, Board of Directors, Center for People with Disabilities.

. . . On Language

Perhaps you can do something about a problem I have. For some reason I always get a little irritated when I read your clever little feature, *Language Used or Used Language*. I don't know, maybe it has to do with the fact that the person who writes the column has language skills which are as poor as those of any of the writers which he or she takes it upon him or herself to critique. The problem is that he or she seems to think that his or her language skills are superior. But let me tell you, Edwin Newman he or she ain't. (I wish the person who writes the column would sign it so I wouldn't have to write "he

(Continued on Cover III.)

AMERICAN REHABILITATION

Volume 9, Number 1

The weakest ink is better than the strongest memory.

Jan-Feb-Mar 1983

3	Learning Disability: An Autobiography	Dale Brown
8	Chronic Mental Patients Quality of Life Studied	Agnes B. Rainwater, Ed.D., and James Fuller
13	Historical Perspective Of Spinal Cord Injury	J. Paul Thomas, Ph.D.
18	Center Studies Management-Employee Relations	Fred Knubel
20	Horticulture: Hiring The Disabled	Charles S. Richman
24	Post-Secondary Education For Deaf People	Theresa Monsour
26	Independent Living In Minnesota	
29	Rehab Engineering Helps Many	

DEPARTMENTS

Cov. II	Commentary	16	19	27	News, Notes, Announcements
2	Topic Of State			28	Language Used
11	Report Resources			32	New Publications

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TOPIC OF STATE

The November 1982 edition of the Wisconsin Division of Vocational Rehabilitation *DVR Newsletter* presents a 16-page special section on rehabilitation engineering.

The following is quoted from administrator Patricia Kallsen's introduction to the section:

"Throughout the history of vocational rehabilitation, there have been times when new development—either technological or legislative—have had a major impact on the philosophy and practice of rehabilitation. Especially in recent years, developments in chemistry, electronics, computers, metallurgy, communications, and education have given rehabilitation practitioners an opportunity to use 'state-of-the-art' technology in their work with severely disabled persons.

"Only a few years ago, such things as talking machines for those who could not speak, reading machines for those who could not see, or robotic devices performing the functions of arms and hands were found only in science fiction. Today, these 'impossible' machines are not only available, but have the potential to be used effectively to provide rehabilitation services to disabled persons the world over.

"As rehabilitation practitioners, counselors, evaluators, educators, and technicians become more familiar with these technological advances, more opportunities for vocational rehabilitation and independent living for severely disabled individuals become possible. At the same time, these innovations have given rise to a relatively new field in vocational rehabilitation—*Rehabilitation Engineering*.

"This special issue of the *DVR Newsletter* will introduce some of you to this new world of technological possibilities. Others of you are already familiar with the scientific ground that has been broken in this area in recent years. For all of you, seasoned veterans of vocational rehabilitation, consumers, interested citizens, employers, community professionals, or graduate students in vocational rehabilitation, we hope to share with you the latest thinking and the newest directions for this exciting field."

Labor Organization Registers Support For Disabled People

The California Labor Federation, AFL/CIO recently adopted a policy statement on the rights of the disabled that is considered to be the most progressive and comprehensive declaration of disabled rights by any organization or government. The policy statement was part of a wide ranging declaration of principles adopted at the Federation's fourteenth convention held in Anaheim in July.

The thrust of the lengthy statement was to affirm the Federation's support for laws that prohibit discrimination against people with disabilities in transportation and education. It also called for a national health policy that is sensitive to the needs of the disabled population. The detail of the statement pointed up the attitudinal problems and statistical proof of discrimination that exists against the employment of people with disabilities. It states support for expanded independent living services, inhome support services, efforts toward securing equal employment opportunity for women with disabilities, and expanded efforts to bring union representation to sheltered workshops.

This policy declaration is another demonstration of the Federation's long standing commitment to provide equal opportunities in the work place and the community for people with disabilities. It is generally felt that the statement, if used effectively, could be a significant factor in moving more people with disabilities into the mainstream of society.

—*Rehab Review*, California Department of Rehabilitation.

Project Trains 185 Visually Disabled

A recent issue of INFOCUS, the house organ of the Burroughs Co., spotlighted a very successful program that Rehab sponsors through the System Development Corporation (SDC) in Santa Monica. Operating for 16 years now, the program has trained 185 people with visual disabilities in computer programming.

The SDC program began in 1966 when the corporation enrolled a blind man in one of its regular computer programmer training courses as an experiment. The experiment was so successful that it led to the first computer training program for people with visual disabilities in the nation.

Rehab's Constance Hubbard, coordinator of services for the blind and partially sighted, was quoted in the article explaining why computer programming is an ideal occupation for the visually impaired. According to Hubbard, such work is appropriate because it is an analytical task requiring chores of observation that can easily be transferred from the eyes to the fingers and ears. Another great advantage is that learning and application of computer skill is much the same for people with visual impair-

(Continued on Cover III.)

Learning To Work:



A Story By A Learning Disabled Person

Dale Brown

My First Job

The first day of my senior year in high school, I eagerly applied for jobs. A drugstore manager hired me as a waitress. I was very excited. Two dollars and sixty-five cents an hour seemed like a fortune to me. And I was thrilled to have my first job. I did not know at that time that I was "learning disabled."

My first impression was of noise and brightness. Cash registers clattered. Dishes crashed. Silverware clanged. We picked up our large white aprons from a hook next to a steel steaming sink. To one side of a narrow aisle was a shiny counter where the customers ate. On the other side was the grill, the bins of food, the soda machines, and the silverware and dishes.

Pam, a slender, young woman explained the system. "First, you take the order." She handed me a green pad. "Put it in your pocket. We're each assigned a section. You can help me with my section today, because it's a training day. Anyway, my section is

here." She gestured, but I didn't know where she was pointing. "OK, just watch me." She approached a customer and said, "May I take your order please?" The customer told her and she wrote it down. I leaned over her shoulder to watch but she pushed me gently away. I didn't see what she did.

"One hamburger," she shouted to the cook.

"Now we have to make the tuna salad. Here's the scoop. You put the lettuce on the plate like this, then put the tuna on top. Then you put the tomato here."

Pam and I had to lean close to the counter to avoid being hit by a man carrying trays and the other passing people. I tried to watch her, as she put the order together, but could barely follow.

"Show me how to do the tuna salad again?" I asked. "I don't remember how to do it."

"I can't until we get another order for it. Now, we clean up the counters by putting the dishes down here. Roy takes them later. . . ."

She spent the day talking to me and telling me detail after detail. I tried to listen to her, but the other conversations, the sizzling of the grill, and the rushing of water distracted me.

"How do you take an order again?" I asked.

"It's easy," she replied. "All you have to do is to write down what they say and then get the prices."

The next day, my own section was assigned to me. Fortunately, my shift began at 2 p.m., which was "off hours" and there was only two customers.

A man and a woman were waiting

expectantly. The man asked for a hamburger and coke. The woman asked for a tuna salad and rootbeer.

I wrote down the order, but didn't know the prices.

"How much is a hamburger?" I asked Pam.

"Eighty-five cents."

"How about a Coke?"

"Was it large or small?"

"I didn't ask."

"Better find out."

"How much is a tuna salad?"

"45¢. Look at the menu, next time. It has all of the prices."

I went to make the tuna salad. I couldn't find the scoop and had to ask Pam for it. The plates had disappeared. Again, I had to interrupt her. I laid down the lettuce, but it wouldn't lie flat. Then I couldn't scoop the tuna. I tugged into it with the rounded scoop, but didn't know how to press the handle to let the tuna out in a ball. So I ended up spooning it on the lettuce and hoping it was enough. Then, I gave the woman her tuna salad.

I checked my list and brought their

drinks, using the first papercups my hand encountered. I couldn't easily see the difference between large and small, and by now, I had forgotten Pam's reminder.

"Where's my hamburger?" asked the man.

"Oh, I'm sorry, I forgot to tell the cook," I replied. "One hamburger," I shouted to him. Fortunately, there was already a hamburger next to him, so I took it and gave it to my customer.

I was feeling quite proud of myself for serving my first order and relaxed for a moment.

"Listen, don't steal my hamburger again," said Pam.

"What do you mean?"

"You know what I mean! The cook made that hamburger for my customer, your's is just now being made! Don't do that again!"

I approached two other customers to take their order. They both ordered hotdogs and tea.

"Where's our check?" asked the first man I had served.

I gave him the check.

He looked at it thoughtfully. "How much are we supposed to pay?" he asked.

"I don't know," I said and took the check back. Panic hit. How much were the cokes?" I made up a price of 30¢, then concentrated on adding them up.

"You owe us \$1.90," I told him, handing him the check back.

"Where are our hotdogs?" asked one of my customers.

"And my order," said another person.

I ignored them.

"You overcharged us for the cokes," said the man. "They cost 25¢."

"O.K., I said.

"We owe you "\$1.80," he said.

I approached the huge-looking

cash-register. I had forgotten how to work it.

"Pam, you need to show me how to work the cash register."

"I showed you that yesterday."

"Sorry, you need to show me again."

She rang up my order, without telling me what she was doing.

When the numbers \$1.90 came up, I said, "I'm sorry. I made a mistake. I overcharged them for the Cokes. They're 25¢, but I didn't change it on my order form."

She glared at me. "Now, we have to make a void slip." She turned on a small microphone. "Mr. Connors, please come to the counter. Mr. Connors, to the counter."

I waited. "Dale, don't you have any other orders to take?" she asked.

I nodded. I had lost the order slip. I checked my pad, my pockets, the floor around me. I would have to ask them again. But who were they? I couldn't remember their faces!

"Dale, come here," said Pam. Mr. Connors was working at the cash register.

He looked at me sympathetically. "You'll catch on soon," he said. "It's only your second day." He showed me how to use the cash register and said, "Try not to make too many voids."

I reached into my pocket and fortunately, the order slip was there.

"Dale, your customers are building up. I'm going to take care of those two and you finish your order," said Pam.

How did she do it, I wondered. She moved efficiently and effortlessly, taking orders, preparing food, and ringing things up.

I brought the hotdogs to the next customer.

The first few days were a blur of confusion and errors. Other employees were kind to me at first, but rapid-

ly grew impatient, as I constantly asked questions. I couldn't memorize the prices, despite studying the menu during breaks and even, taking one home to work on it. I kept on forgetting where the plates, silverware, and tools were located.

"Where's the scoop?" I asked Pam once.

Right in front of your nose," she replied. She pointed to it, and suddenly it appeared. Today, I know that this is a typical symptom of visual figure-ground problems, but then, I didn't understand why things disappeared and then, suddenly reappeared.

Preparing food was difficult, even after learning how to do it. For example, to fix a coke, one took a paper cup, pushed it against a knob under the nozzle. It required a lot of seltzer water and a small amount of coke syrup. I couldn't tell the difference between the knob for seltzer water and the knob for coke syrup. The left knob and the right knob seemed the same and so did the two labels. My only choice was to squirt a little bit of liquid into the cup, check and see which it was. Then if it was coke syrup, I had to remember to only put a little bit of it and a lot of seltzer water. Since the coke syrup looked like coke, it was easy to serve a lot of coke with a tiny bit of seltzer water. The customers would comment on my funny tasting cokes!

I never figured out the sequence of putting an order together. Now, it seems clear that you start with the cooked items and work on your other food while they are cooking. With my inability to conceive of time properly, it was not obvious, and nobody told me. So, I always served my customers their food at different times.

I had trouble walking back and forth in the small space between the counter and food preparation area. I

often bumped into other workers or dropped things. Once, I dropped and broke a tray of glasses.

Because of difficulty in seeing and remembering faces clearly, I often confused their orders. I concentrated hard on each face. Sometimes, I would count and write the number of stools from one end. Unfortunately, I often miscounted or skipped one of the stools. Once, I wrote down "blonde hair and blue eyes." The customer laughed when she saw that.

A few times, I went down the aisle and said, "Who ordered the hamburger and coke?" Someone always took it.

Gradually, I mastered the cash register, although I had a tendency to punch the wrong numbers and end up with \$13.80 instead of \$1.38. The tax table print was so small, that I sometimes guessed the tax or forgot it all together.

My favorite job was going to the stockroom to get ice. The other waitresses hated it. I loved it and got almost all of the ice. I would walk downstairs holding two buckets, one in each hand. Then, I'd sit on a carton for a few minutes to calm myself. Then I'd fill each bucket with a scoop, enjoying the rhythm of the ice hitting the bucket. When it was full, I took it upstairs and poured it into each icebin.

I was cheerful and most of my customers were sympathetic. Whenever, they pointed out my errors, I apologized and immediately corrected them, before going on to my next orders. I asked them to find the prices on the menu. I'd often ask, "Have I forgotten anything? Can I do something else?"

Due to my cheerfulness, reliability about coming in on time, and obvious eagerness to please, the manager liked me. Sometimes, Mr. Connors kidded me about all of my void slips, but he

was very patient. My coworkers, on the other hand, had to constantly answer my questions and correct my errors. Even though I took care of some of the unpopular jobs, they found me difficult and were undoubtedly glad when I had to leave, due to a change in bus schedule.

Later, I had many jobs. I was a salesgirl in a department store during Christmas rush. You can imagine the problems! At Pitzer College, I woke up at 6 a.m. to clean the dormitory kitchens. I loved that job, because I worked alone and at my own pace. After transferring to Antioch College, I became a cafeteria worker and served food, washed dishes, and helped the cooks. I did each job better than the last.

Discovering My Learning Disabilities

As I worked, I often wondered why I had to try so hard. Everyone else could do the work so easily. They picked it up quickly, not needing as much training and attention from the supervisor. If I concentrated hard and did everything correctly, I was accused of being too slow. On the other hand, when I went faster, I made errors. Other people could do the job correctly and at the right speed. No one else had to work during the breaks or worse, punch out then return to complete undone tasks.

The answer to that question came after working at an electronics factory during a work study quarter. There, I realized that I must have some kind of specific problem. My productivity was very low. For example, we had to strip wires, cutting one layer of wires with a razor blade, without cutting into the next layer of plastic. I had trouble using the right amount of pressure. Either, I'd cut into the next layer of wires or not cut through the first layer. Sometimes, the thin copper wires broke as I

twisted them. I often cut my fingers.

One day, my supervisor asked me to strip "eighty" wires. I was doing the job, when she said, "Dale, it's taking you an awfully long time to strip those eight wires."

"You said 80 wires," I replied surprised.

"I said eight."

"No, you said eighty."

"I said eight!"

"I heard eighty," I replied. What was it? Was it my hearing? It had been tested several time and was considered good. Yet, there was no question about it, I often misheard instructions. I knew about my clumsiness and difficulty in seeing correctly. But, I had assumed my hearing was fine.

After leaving that job, I visited a counselor who told me that my mistakes were similar to those of children with something called learning disabilities. She sent me to the library to read about the topic. At that time, learning disabilities were assumed to be outgrown in early adulthood.

My research was revealing. My handicap had a name! There was a reason for all that extra hard work! Each problem was actually a symptom of a disability. If only someone had recognized all of that extra effort. For a few weeks, I felt sorry for myself and wished for the praise that was deserved, but never received.

Basically, however, information about my learning disability was very useful. Weaknesses, I realized, could be worked on systematically. For example, many learning disabled people can't use one side of their body well.

In my case, I dropped things, because the muscles of my right arm would suddenly relax. So I decided to carry items with the weight on my left arm. That solved that problem.

My knowledge of my learning disabilities was particularly essential

(1) Be prepared to spend extra time learning the job, even if you are not paid extra. Bring price lists home to memorize. Practice filling out forms. If you are working at a chain of restaurants, go to a different restaurant within the chain and watch the workers. If you are slower, be willing to take extra time to finish your fair share of work.

(2) Ask for help as you need it. Even though other employees and supervisors may act impatient, it's better than making errors.

(3) On the other hand, never ask for help if you don't need it.

(4) In most jobs, accuracy is more important than speed. Take the time to do it correctly, even if people pressure you to go faster.

(5) Take full advantage of your first few days on the job. During this "honeymoon period," you can ask questions. Try to find someone who will watch you do the job correctly. Repeat information. Say "Please listen to me tell you, so I can be sure I understand." Don't let them interrupt you and tell you what to do. Be sure they are listening to you. Some people like helping others. Try to find them.

(6) Offer to do tasks which you can handle but that others consider unpopular. Then, you can ask others to assist you with jobs that you can't do.

(7) Develop ways of remembering important facts. Everyone has a particular technique. Write things down. Or, say them aloud when you are alone. Or ask your friends or parents to drill you.

(8) When you make mistakes, apologize and correct them immediately.

(9) Report on time. If you have trouble being on time, try to arrive an hour or two early.

(10) Try hard and *appear* to make an effort. Sometimes, when one makes mistake after mistake, it gets tempting to act indifferent or as if you are doing it on purpose. That isn't helpful. Make your effort obvious. That means:

—Appear to pay attention. Look everyone in the eye. Nod your head occasionally as they speak. Respond to what they have said.

—Look at your work as you do it. Don't let your eyes or mind wander when you are on the job. Walk purposefully from place to place.

—Always work, except during breaks or lunch.

—As you improve, tell your supervisors and coworkers. Say, "Thank-you for your help. As you can see, I did it correctly this time."

during my first job after college graduation, working as a court reporter. Obviously, this was not the right job. However, during the recession of 1975, there were very few jobs, and I was lucky to get one, even as a court reporter.

I had been searching for 5 months, when I applied for the job. Helen, who directed the company, showed me a large black box, which came to my hip.

"Can you lift that?" she asked.

I picked it up, keeping a straight

face, and hiding my breathlessness.

She nodded. "There will be two of these and you will have to carry them all over the place." She told me that I would be responsible for taping the trials so that the typist could produce an accurate transcript. That meant correct spelling and good, sound quality.

Listening to her, I wondered if I could do the job. Clearly, I'd go right up against my learning disabilities. With inaccurate hearing, vision, and touch, it would be a challenge to do the job correctly. But I needed a job! So I enthusiastically sold myself during the interview. They chose me.

On my first work day, they assigned Paul to show me how to use the equipment. Now that I could realize that it was impossible for me to learn it all the first time, I relaxed and absorbed as much as possible.

He showed me how to thread the tape, set up the microphones, attach them to the mixer box, and attach that to the tape recorder. After his explanation, I asked him how to thread the tape.

"I need to do it and have you watch me and let me know when I do it right." He agreed.

When I threaded the tape correctly, we went on to the next step.

Knowledge of my learning disabilities kept me calm and matter-of-fact, although I knew my method of learning was unusual and slow. When Paul became impatient, I thanked him and convinced someone else to watch me do the other steps. Then I took the heavy equipment home and practiced using it.

When Paul took me to a trial, where he was recording, I watched carefully and asked questions. At the end of the day, I still did not under-

stand what to do, although the major points were becoming clear.

"I'm sorry, but I still don't feel ready to work on my own," I said. "Can I spend tomorrow watching another reporter?" He asked Helen, who let me have several extra training days.

Our training paid off. While, it took me longer to record trials, the transcribers told my boss that they liked to receive my work, because it was easy to follow. And, once, a judge requested me.

Meeting Other LD People

But my hunt for a more appropriate job continued. Finally, a professional association hired me as an office manager. This job also required overcompensation. My workweek was about 60 hours long. The business manager jokingly threatened to charge me rent, because I was there so often.

During this job, I often felt lonely. I had finally found a professional job in which I could succeed and advance. But the price was spending most of my time in the office. Was life only work? I decided to seek people with other disabilities. I hoped it could be coped with more efficiently.

Since the handicap is invisible, forming a self-help group seemed the only way to meet others. Thus, I started Association of Learning Disabled Adults (ALDA). Meeting other learning disabled people made me realize how severe our handicaps are. Many people in ALDA couldn't even hold a job. Either, they couldn't find them or they were frequently fired.

We had no access to help from professionals, since we supposedly outgrew our disabilities. Our problems were considered minimal. We

were told that we weren't trying or that we were being careless. The help we could give each other was our only chance. But that should not have been. We deserved the help that people with visible handicaps received.

I decided to look for work in an organization that dealt with disabled people. There, I could learn about the field and tell other people about learning disabilities. Fortunately, my job, which was on a federal contract, was ending.

I read Richard Bolles' *What Color is Your Parachute?*, a well-known book on job-hunting. It suggests that you study the places you want to work, meet the people who can hire you, and interview them for information, rather than as an applicant. So I called on private and government agencies with programs for disabled people and talked about ALDA. The reception by these agencies was warm, welcoming, and interested. Sometimes, I spent so long on the topic of learning disabilities, we forgot about my job hunt!

One group that interested me was the President's Committee on Employment of the Handicapped. I visited them and read a stack several feet of publications from their stockroom. One was by Bob Ruffner, their Director of Communications. I wrote to him and complimented him on his article. He responded by arranging to meet me and have me interviewed by the Committee's magazine *Disabled USA*.

Before visiting him, I did my homework. I researched the agency in the *Periodical Guide to Literature* in my local library and read everything written about it. I obtained the Committee's radio public service announcements from a friend at a local radio

station. I asked people in other organizations about it.

A job opened up at the Committee. I filled out form after form, and after 5 months of being interviewed, of waiting, or refilling forms, of competing against many other qualified men and women, I got the job!

Today, I am on the Committee staff, promoting opportunities for disabled people through writing, public speaking, and special events. I enjoy the work, doing things that I'm good at. My job can be done in a reasonable amount of time.

It has not been easy for me to find my place in society as an LD adult. It took hard work, self-discipline, and positive thinking. I had to demand the training that was needed in each situation. In the accompanying sidebar, I've written the "coping skills" which most helped me.

On the other hand, I was born with many advantages. My family was warm and supportive. They paid for my college education. It was always clear to me that blue-collar work was temporary.

What happens to people with these disabilities who are raised in factory towns? Or those who cannot afford a college degree? Or those who are not intelligent or emotionally stable? What happens if you are not qualified to be a professional, but can't do entry-level jobs either? These are the people that we must help. I hope this story gives some clues as to how.

Dale Brown is a program manager at the President's Committee on Employment of the Handicapped. She is grateful to Bob Ruffner for his help on this article. Ms. Brown has been a frequent contributor to AR on the subject of learning disabilities.

Chronic Mental Patients' Quality Of Life Studied

Agnes B. Rainwater, Ed. D., and James Fuller

Quality of life is becoming more important for all people, and it can be defined as the positive life forces in which physical, mental, psychological, and social areas harmonize. The term includes anticipation, joy, and contentment. It is judged by self and society and varies with age and environment. This paper presents a cooperative program in which leisure and recreation are used as factors in its attainment. We discuss the importance of leisure and recreation in maintaining mental health, the study and program design, program goals, client benefits, student participation, university and the agency involvement, characteristics of client within the program, the activities conducted, and client reactions.

Mental health involves all phases of life: work, leisure, recreation, family, and community. The importance of leisure and recreation within a person's life is now recognized as a basis of mental health.¹

We use the holistic concept of leisure which we define as a state of mind or state of being which views leisure as "a construct in which elements of leisure are to be found in work, family, education, and religion and, conversely, elements from these constructs are to be found in leisure."² We define recreation as any activity, individual or collective, active or passive, freely chosen and giving satisfaction.

Diversion alone is no longer accepted as a recreational outcome. Recreation must provide real experiences and learning whereby a person acquires positive attitudes, a variety of skills and interests that contribute to a more satisfying and meaningful life. This does not mean that recreation should not be enjoyable.

The study, "*Evaluation of the Quality of Life of the Schizophrenic Outpatient: A Checklist*,"³ showed that knowledge and education, relationships, and leisure were three of nine areas in which 40 schizophrenic patients responded with "unsatisfactory" ratings. Most of the clients said that the only activities with which they were comfortable were those that enabled them to be withdrawn and solitary. Malm⁴ reported that "Most were satisfied with their TV (35 of 40) and radio (36 of 40); 28 were satisfied with their music (mostly pop or rock music on tapes or records). All other leisure categories contained many deficiencies."

Many mental clients remain isolated because they cannot interrelate nor develop the skills needed to develop these relationships. They want to interact, yet fear interaction, and so return to isolation.

Study Design

Both mentally ill and healthy people gain from agency cooperation with each other. Scarcity of funds, short-

ages of trained recreation personnel, and inadequate facilities almost make this cooperation a necessity. Such a joint effort was made by the Community Mental Health Center of Lancaster County (drawing from the Adult Day Treatment Center population) and the School of Health, Physical Education and Recreation at the University of Nebraska, Lincoln (using students from two undergraduate therapeutic recreation classes).

The authors conducted a leisure and recreation program for 25 Mental Health Center clients for 1½ hours per week for 8 months. The clients participated in physical fitness; individual, dual, and team physical activities; informal games; New games, dance; informal drama; relays; mental games; and discussions. Seven therapeutic recreation students were involved in program planning and leadership.

Because of the short term attendance, individual assessments were impractical so that a general assessment considered the needs and interests of emotionally disturbed adults, as well as the needs and interests of "normal" adults, ages 19 to 39.

Overall objective was to establish an experiential program between the University and the Mental Health Center that would determine the effectiveness of recreation skills in facilitating integration into the community.

The authors met to establish the program's scope and objectives. Students also met with the principal author to establish activities to be included to meet goals and objectives, student responsibilities, and program expectations. Subsequently, students and the principal author met weekly to evaluate the previous session, receive feedback from the mental health staff, and discuss possible changes.

This university program was additional to the recreation therapy conducted at the mental health center which avoided duplication while presenting broader opportunities for a wider range of recreation.

Program Design

The program would provide skills, interests, and resources in helping clients in community integration. Meyer⁵ said: "Many aspects related to successful play and recreation participation in the motor and social realm, for example, are directly related to success in other areas of living; the ability to receive and express language symbols (communication); the ability to use the physical body as a mode of expression and to accomplish tasks; the opportunity to gain competence in a variety of social roles such as a giver, receiver, leader, follower, etc." Recreational experiences and activities generalize to other roles, whether they relate to work or to living in a board and care home.

Participation was voluntary. The Day Treatment clients were involved in a rehabilitation program with job attainment and further education as their goal. The Day Care population was identified by the reduced level of their therapeutic goals because of severe degree of dysfunctional behavior and lower motivation, with a marked degree of chronic/institutional behaviors. Because of these characteristics, program development included consideration of specific activities to provide skills, interests, and resources to help them become part of the community at their own functioning levels.

Goals

Goals for the program were: 1) to establish an ongoing experiential program between the University and Mental Health Center to determine

effective recreational skills as a means of facilitating mentally ill persons to more easily fit into a community setting; 2) to provide opportunities for clients to learn new skills in all areas of recreation which would aid their adjustment to society; and 3) to create opportunities for experiential learning to augment classroom education for the university students.

Client Characteristics

A predominantly male population (22 of the 25 clients) ranged in age from 19 to 37, with a mean of 24. All but four were high school graduates. Two were college graduates, with six having some college education. Twenty had the diagnosis of schizophrenia. Three clients were diagnosed with borderline retardation, and inadequate personality accounted for two of the people. Five came from upper-middle, socio-economic background. Two were considered at the poverty level, and the rest were middle class.

Activities

The Mental Health Center program provided arts and crafts, pool, table tennis, volleyball, and some table games. To prevent duplication and allow for a variety within recreational experiences, we decided not to include Center activities in the University program. We determined that the clients needed more physical activities, and the University had the facilities, equipment, and teaching personnel.

The physical activities included New Games, fitness, bocce, frisbee, soccer, golf, tennis, flag football, softball, badminton, goodminton, basketball, and cooperative games.

The general planning for each session was divided into four segments: fitness; group activities, individualized skill practice; and "wrap up"

which involved a discussion on community recreation opportunities in which the clients could use the skills they had practiced that day and also the recreation opportunities that might be of interest to them.

Student responsibilities involved planning and teaching of skills, participating in the activities, assessing the activities through observation and reviewing of the goals.

Discussion

The program progressed very well. However, because the MHC is a short term facility, it was difficult to have continuity and follow-through with some of the clients. It would be most desirable to have an ongoing recreation program (with the University) each day, so progress would occur and continuity would be assured.

The activities that were done out-of-doors were enjoyed. More things should be planned and conducted in this environment. Physical activities were by far the most popular. A factor here might be the age levels and the fact that a large majority of the clients were men.

It was interesting to note that the clients requested many of the physical activities to be played on a more competitive basis. They did not want to "just play the game," but wanted definite rules and scores. Even the new games became somewhat competitive. In all but two instances, the clients were able to enter into a competitive activity and enjoy that activity as a game and not become overstimulated or fearful. They were able to maintain control in fairly anxiety-provoking situations that competition encompasses.

Some of the activities involved physical closeness, which is often threatening to the schizophrenic. Yet all the clients were supportive and became involved in these activities,

which included the Virginia Reel, skin the snake, electric fence, knots, as well as in games which required a high degree of physical closeness and cooperation in solving problems. Relay races at first were perceived as juvenile, but clients were able to "shed" inhibitions and join in.

Badminton was introduced at too high a level of skill, so we had to break it down into the individual skills, as the clients had difficulty with hand-eye coordination. However, three of the people were highly skilled in all the physical activities. The highly skilled people aided others in acquiring skills.

Table games were not received as positively as the other games. Clients were looking forward to the physical activities and were not receptive toward the quiet, thought-provoking skills. Another factor may be that they had table games at the Center.

A motivational game to promote reading the newspaper was very well received. It was hoped that this activity would encourage the clients to read the daily community newspapers. The game used the student daily newspaper for each client, along with an instructional paper which designated captions from pictures, key words for advertisements, and people's names within the articles. The clients had to find key words or phrases and circle them. After completion, we discussed the items and helped those who could not find the captions.

Program Results

This program was a learning experience for students in working with mental health center clients. For some it was a positive experience that heightened interest and encouraged continuation of education in the field of therapeutic recreation for mentally ill persons. For other students, it clearly demonstrated that they would

be ill-suited to work in this area. They learned that working with mentally ill can be frustrating and an anxiety-producing experience. The students discovered that a therapeutic recreation specialist must be adaptable and innovative in conducting programs. They found that an activity that worked very well one day did not work at all the next day.

In debriefing sessions with the authors, the students commented that the clients had similar backgrounds to their own. Clients did not fit the stereotypes of chronic mental patients. Students realized that the clients had the same leisure interests and other needs as their peers and contemporaries. Students noted that the clients would approach them with ease when meeting in the community, indicating a "comfort level" between the students and the clients.

We have had difficulty evaluating the impact of the program in relationship to what the clients are doing within the community because of rapid turnover within the treatment program and the lack of community resources in which clients can participate. We need to do some followup on the activities in which the clients are participating within the community.

However, it is interesting to note results for some of the clients with whom we have been able to maintain contact. One man, age 22, former University of Nebraska student with competitive skills in gymnastics, had withdrawn from society completely after "breaking up" with his girlfriend, failing three courses, and being dropped from the gymnastic team. He participated in our program for six months. By the end of four months he was taking an active leadership role in all of the activities. He was responsive to community activities with other clients. He did ask one of the recreation students involved in

the program for a date, but was refused. He did start dating two girls and has been a spectator at gymnastics meets on campus. He has spoken with his family concerning going back to school, but will not commit himself to a definite enrollment date.

One of the three women is no longer in the day treatment nor the UNL program, but does live in a group home. Since being in the UNL program she has participated in mental health center group-sponsored community activities, but will not initiate activities on her own outside the home. She is reading the newspaper and is walking half a mile each day, although she still views television four to six hours each day.

These two examples show different levels of progress with the clients, but do demonstrate the fact that the program has had a positive effect on their leisure life.

Dr. Rainwater is a master therapeutic recreation specialist and an assistant professor at the University of Nebraska-Lincoln. Mr. Fuller is a mental health specialist at the Community Mental Health Center of Lancaster County, Lincoln.

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ARKANSAS REHABILITATION RESEARCH AND TRAINING CENTER ANNUAL REPORT NUMBER SEVENTEEN. (Grant #G008003045/NIHR.) Arkansas Rehabilitation Services/University of Arkansas. An ongoing program of rehabilitation research and training with emphasis on the psychological, social and vocational needs of the severely handicapped. They demonstrated the effectiveness of using the resources of a major university, regional rehabilitation agencies, and vocational agencies in carrying out a research and training effort in rehabilitation. For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/637-5822, TDD 202/635-5884).

FUNCTIONAL ELECTRICAL STIMULATION OF PARALYZED NERVES AND MUSCLES (Core Area). (Grant #G008003002/NIHR.) Annual Reports (1977-1981) of Rehabilitation Engineering Center at Rancho Los Amigos Hospital, Downey, California. For copies contact:

Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

INTERNAL TOTAL JOINT REPLACEMENT (Core Area). (Grant #G008003034/NIHR) Final Report of the Rehabilitation Engineering Center at Northwestern University, Chicago, Illinois. For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

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bilitation services; 2) develop a model head injury rehabilitation program; 3) identify rehabilitation problems; 4) disseminate information regarding head trauma and its treatment. For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

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AFFIRMATIVE ACTION TO EMPLOY MENTALLY RESTORED PEOPLE. (1981) Partnership, Public Inquiries, National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD 20857.

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ALL THINGS ARE POSSIBLE. Yvonne Duffy. (75 women... share their most intimate feelings about themselves, their mates, their children, and their worlds.) A. J. Garvin and Associates, P.O. Box 7525, Ann Arbor, MI 48107. \$10.10.

PARTICIPATION OF PEOPLE WITH DISABILITIES: AN INTERNATIONAL PERSPECTIVE. Kathleen S. Miller, Linda M. Chad-

derdon, and Barbara Duncan, editors. University Center For International Rehabilitation, 513 Erickson Hall, East Lansing, MI 48824. \$4.50.

LESSONS FROM P.L. 480—TWENTIETH ANNIVERSARY OF THE REHABILITATION SPECIAL FOREIGN CURRENCY PROGRAM (AN EVALUATION). (Grant #G008006811/NIHR.) Final Report of the World Rehabilitation Fund, Inc. The National Institute of Handicapped Research and the World Rehabilitation Fund jointly sponsored a two-week seminar in commemoration of the twentieth anniversary of the international research program. The seminar assessed the benefits derived from the international rehabilitation research and interchange of expert programs administered by the National Institute of Handicapped Research under P.L. 83-840 and P.L. 86-610. It was also a major U.S. activity in observance of the United Nations International Year of Disabled Persons.

The report discusses the background of the international rehabilitation research and demonstration program of NIHR; the organization of the seminar; and the conduct, design, findings, and recommendations of the seminar conference. Also included, is a list of seminar participants from overseas; U.S. participants; a bibliography of rehabilitation papers submitted for the Seminar; examples of benefits derived from cooperative international rehabilitation research under P.L. 480, and suggested areas for future research; and the Seminar agenda.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University

(Continued on page 15.)

Historical Perspective Of Spinal Cord Injury

In the words of Sir Ludwig Guttman, "Of the many forms of disability which can beset mankind, a severe injury or disease of the spinal cord undoubtedly constitutes one of the most devastating calamities in human life." This is readily understood if one realizes the paramount physiological importance of the spinal cord not only as the main transmitter of all impulses and messages from the brain to all parts of the body and vice versa but also a nerve center in its own right, controlling vital functions such as voluntary movements, posture, bladder, bowel, sexual functions, as well as respiration, heat regulation, and blood circulation. Therefore, a severance or severe injury of the spinal cord, whether caused by trauma or disease always results in disability of great magnitude.

Such an affliction has naturally aroused medical interest, and references to spinal cord injuries have been found in records from early periods of civilization. The Edwin Smith Surgical Papyrus, written about 5,000 years ago by an Egyptian physician, contains a cogent description of the major symptoms of a complete lesion of the cervical cord, following dislocation or fracture of the spine. In discussing the prognosis and therapy of such patients (cases 31 and 33 of the Papyrus), the comment of the unknown author is as brief as it is significant: "An ailment not to be treated." It is not known whether this ancient author generalized his pessimistic attitude to all levels of spinal cord lesions, but it must be agreed that the sentiments expressed have

J. Paul Thomas, Ph.D.

prevailed throughout thousands of years among most members of the medical profession.

Hippocrates, about 400 BC, described chronic paraplegia, mentioning constipation and dysuria, as well as edema of the lower limbs and decubitus ulcers, as complications. Hippocrates also introduced novel methods of reduction of deformities of the spine by traction, and his famous extension bench, better known through the work of Aulus Cornelius Celsus, was employed in various modifications by physicians throughout the centuries to reduce fractures as well as other deformities of the spine. Roland of Parma, Professor at Salerno, in his *Chirurgia* (1210), discarded the use of Hippocrates' bench and used manual extension only. For dislocation of the thoracolumbar spine, the patient was placed in supine position and the medical attendant pulled on his legs, while an assistant held the upper part of the body. For the reduction of the cervical spine, the patient was placed in sitting position, the physician braced his feet on the patient's shoulders and pulled his head briskly with a folded cloth passed beneath his chin. However, the famous French surgeon, Ambroise Pare, in his *Dix-Livres De Chirurgie* (1564), reverted to Hippocrates' extension method in prone position but used it with greater caution by reducing the fracture or dis-

location by manual pressure and immobilizing the vertebral column after reduction by splints or specially designed lead plates. The patient was then turned on his back and kept in that position. This extension technique in prone position with manual reduction of the vertebral fracture or dislocation was still used into the Nineteenth Century.

Surgical intervention in spinal injuries has been discussed and described long before the modern principles of asepsis were discovered. Among authors of ancient time, Galen reported on experiments on the effect of longitudinal and transverse incisions of the spinal cord. Paulus of Aegina modified Hippocrates' method of traction for vertebral dislocations by using external fixation of the reduced spine by a thin sheet of wood extending above and below the site of injury. He is considered as the originator of decompressive laminectomy and also advocated removal of a fractured spinous process causing pain.

During the first quarter of the Nineteenth Century, arguments on indication and value of laminectomy were widely discussed among leading members of the medical profession, and the management of spinal injuries became a topic of interest in England and other European countries.

Throughout the Nineteenth Century, the tendency in the treatment of spinal cord injuries, however, remained conservative. Interestingly a famous personality in British history, Lord Nelson, was a victim of spinal cord injury, the result of a gunshot wound during the Battle of Trafalgar.

The final scene in Nelson's life was recorded by Beatty, the ship's surgeon, and has been described in detail in Oliver Warner's book, *Trafalgar*, from which the following is quoted: "Mr. Beatty was called by Dr. Scott to Nelson, who said—'Ah, Mr. Beatty! I have sent for you to say what I forgot to tell you before, that all power of motion and feeling below my chest are gone.' The surgeon's reply was: 'My Lord, unhappily for our country, nothing can be done for you'." Nelson died within a few hours.

The developments in surgery in the Listerian period, Pasteur's work on bacteriology, the introduction of ether anesthesia, and later the discovery of x-ray have, no doubt, modified the extremely conservative view, and the field of spinal cord surgery has steadily been expanded. However, the prognostic outlook of sufferers from severe lesion of the spinal cord has remained extremely poor and the mortality rate in both peace and war has been high. This historically hopeless attitude, held even by experts, has been appropriately summarized by Wagner and Stopler (1898), a work which up to the first World War was considered as a standard text on the subject of spinal injuries. Their views are expressed as follows: "In complete lesions it is the physician's forlorn task, even while knowing that the patient is approaching an early death, to keep him alive for weeks and months on end, only to see him wretchedly fade away, despite all skill and efforts."

Harvey Cushing, the world famous neurosurgeon and consultant in neurosurgery to the American Army during the first World War, gave, in 1927, a vivid description of the fate of battle casualties with spinal cord injuries, 80 percent of whom died in the first two weeks. "The conditions were

such," he wrote "owing to pressure of work, as to make it almost impossible to give these unfortunate men the care their conditions required. No water beds were available, and each case demands undivided attention of a nurse trained in the care of paraplegics. Only those cases survived in which the spinal lesion was a partial one."

Prior to and during the second World War, the defeatist attitude of most members of the medical profession was still prevalent, and the general attitude of despondency is revealed in the 1924 report of the British Medical Research Council: "The Paraplegic patient may live for a few years in a state of more or less ill-health." Martin (1947) aptly summed up the unsatisfactory situation as follows: "The record attained in World War I is not a very enviable one and it is quite apparent that the methods of treatment of traumatic paraplegia were not improved by the rich experience of that war." The victims of war and industrial accidents did not produce an overt social problem as, in the majority of cases, their life expectancy was very short. As a result of sepsis from infection of the urinary tract and pressure sores, medical complications were considered inevitable. Therefore, any attempt to restore such persons to their former activities seemed out of the question and the view generally held was the sooner he died the better for all concerned. It is, therefore, not surprising that, in discussions on rehabilitation during the World War years, the subject of rehabilitating victims of paraplegia was hardly mentioned in spite of the fact that modern principles of rehabilitation had been successfully applied for a number of years to other impairments. In closing the history books on spinal injury at this point, it is interesting to note that

the renowned Ludwig Guttman, reporting on the first conference on rehabilitation of injuries to the central nervous system of the Royal Society of Medicine, spoke on peripheral nerve injuries and four speakers discussed head trauma. Not one word was uttered about spinal cord injury! That was 1941.

Later in the course of the second World War, a radical approach to spinal cord injury management was advanced by the British Medical Research Council. It was decided to gather spinal cord casualties in special care units within the ministry of pension hospitals throughout Great Britain. The English were faced with the catastrophic potential of many civilian air raid casualties in addition to large numbers of their military personnel receiving CNS trauma from war injuries and accidents. In 1943, British authorities established a new spinal care unit at the ministry hospital, Mandeville in Aylesbury. With the opening of this unit on February 1, 1944 and with the leadership of Sir Ludwig Guttman, a concept of comprehensive treatment and rehabilitation was introduced. By 1951, when Stoke Mandeville Hospital was acquired by the National Health Service, the unit had a complement of 160 beds. With its designation as the National Spinal Injuries Center, admitting patients from all parts of the United Kingdom, the bed capacity increased to 195.

Concurrently, in the United States, several significant developments in categorical care were taking place. At the Boston University Hospital, Dr. Donald Munro, with the sponsorship and assistance of Liberty Mutual Insurance Company, established a 10 bed spinal injury unit. Dr. Munro was also a consultant to the Veterans Administration. This federal agency established six specialized spinal

injury services throughout the U.S.

All of these specialized programs, while rudimentary, had several common features. These include:

1. Most important of all, supervision of the unit by an experienced physician or surgeon, prepared to give up part of his own specialty in order to devote full time to the work which demanded meticulous attention to detail, to plan and organize the many aspects of treatment, and to coordinate the sometimes conflicting interests of the medical and surgical specialists concerned with the immediate and long term management.

2. Nursing and other allied health personnel such as physical and occupational therapists sufficient in number to cope with the many details involved in the care.

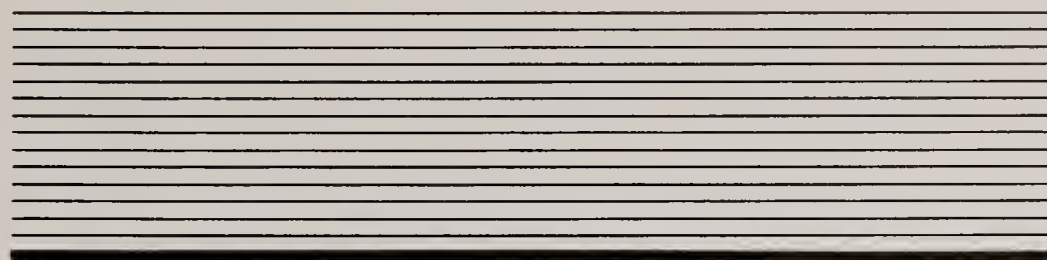
3. Adequate technical facilities such as laboratories and workshops for the rehabilitation of long term patients.

4. Arrangements for community and vocational placement.

5. After-care by regular check-ups of patients discharged from hospitals.

Thus, it was through the combined efforts of dedicated and tenacious physicians in several countries that the first hope was generated that the extensive medical, psychological, social, and vocational needs of the spinal cord injured could be effectively addressed.

Dr. Thomas is Director, Medical Research Office, National Institute of Handicapped Research and Project Manager, Model Spinal Cord Injury System, RSA. The article is the introductory material from his presentation at the Eighth Scientific Meeting of The American Spinal Injury Association, April 19, 1982, New York City. The paper was presented as the inaugural lecture of the G. Heiner Sell Distinguished Lectureship.



(Continued from page 12.)

REPORT RESOURCES

of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

THE TRANSPORTATION PROJECT, TRAINING AND EVALUATION PROGRAM IN THE UTILIZATION OF ACCESSIBLE BUSES. (Grant #G008003044/NIHR). Final Report of the Rehabilitation Research and Training Center No. 9 at the George Washington University. The Transportation Project fostered the involvement of rehabilitation professionals in the issue of accessible public transportation.

The RTC working with the Washington Metropolitan Area Transit Authority (WMATA) in developing and implementing accessible fixed-route bus service in the Washington metropolitan area. There are manuals, films, videotapes, and slides available for bus operators, trainers, managers, consumers, and allied health professionals. Although these materials focus on lift-equipped and kneeling buses and some of the federal guidelines have changed, the basic materials will be of interest and assistance to any transit authority jurisdiction, allied health practitioner, consumer, or rehabilitationist interested in accessible transportation.

For copies and project materials contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E.,

The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

PROGRAMMATIC RESEARCH ON EMPLOYMENT PREPARATION FOR THE HANDICAPPED (PREP). (Grant #G008003011/NIHR.) Final Report of the Human Resources Center, Albertson, New York. The overall purpose of Programmatic Research on Employment Preparation (PREP) has been to identify a Career Development Model applicable to physically disabled persons and to test elements of the model. PREP has attempted to address this purpose by exploring strategies in career education, vocational rehabilitation (especially related to placement issues), and the world of work as experienced by disabled persons and their employers.

The final report contains the major findings of the five years of Project PREP. Because the work of PREP is so extensive and complex, detailed descriptions of studies are not included as part of the text (the appendices contain full reports) except where not reported prior (as in several Employment Research projects).

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/645-5884).

NEWS, NOTES, ANNOUNCEMENTS

Univ. Of Chicago Research Clears Understanding Of MS

Recent techniques in multiple sclerosis (M.S.) research are giving scientists a clearer understanding of this disease which could lead to a means for its treatment or cure. Research at the University of Chicago has helped to explain the mysterious disappearance of one type of lymphocyte (a white blood cell that fights infection) which occurs just before the onset of an attack of M.S. The lymphocyte in question is called the "suppressor T-cell."

In searching for the cause of this strange disappearance of suppressor T-cells, scientists used agents called monoclonal antibodies. These laboratory-synthesized antibodies have the ability to selectively locate and attack specific cell components (antigens) of diseased cells. Using monoclonal antibodies as "detecting devices," they found an antigen called T-8 on both suppressor T-cells and the brain cells that manufacture the myelin sheath of nerve fibers in the brain and spinal cord. Because T-8 indicates the presence of disease, and it is found on both types of cells, it is possible that the same disease process attacks both, bringing on an M.S. attack and destroying suppressor T-cells at the same time. This theory would explain the disappearance of suppressor T-cells with an M.S. attack and their reappearance when the disease goes into remission.

Should these and other studies show that M.S. is the result of a defect in the body's immune system, monoclonal antibodies could be the

means of locating that defect and finding ways to correct it. For this reason, this latest research is considered to be an enormous step forward in the fight against this debilitating illness.

Needs Assessment Of Services To Deaf-Blind People

In a recently completed study of the deaf-blind population, its size was found to be just under 750,000—much larger than previous estimates. The study was completed by REDEX, Inc., of Silver Spring, Maryland.

The study was jointly commissioned by two divisions within the Department of Education, Special Education Programs and the Rehabilitation Services Administration, who are responsible for the federal role in providing education and rehabilitation services to deaf-blind children and adults.

The study analyzed services by the number and characteristics of deaf-blind persons dispersed across the U.S. Interviews were conducted with service providers, parents, deaf-blind adults, and government planners. The interview data were associated with information from a review of literature and with evidence from inspection of facilities. These information sources determined the relationship between needs and the services available to meet the needs. Specifically, the final report provides information on:

- The size and demographic nature of the deaf-blind population;
- The array of services, public and private, available for the population;

- The adequacy of services and their present and future service needs;
- The multiple resources required to meet their educational and rehabilitational needs; and

- A continuum of program options to meet the lifetime needs of the deaf-blind population and their families.

A copy of the report can be obtained from Rodney Pelton, Director of Education, Rehabilitation Services Administration, Switzer Building, Room 3532, 330 C Street S.W., Washington, D.C. 20202.

Rehabs Drop; Earnings Are Up

While funding for rehabilitation services has increased marginally over the past several years, the number of persons rehabilitated has declined.

Rehabilitation Services Administration figures indicate that inflation and dealing with a more severely disabled population have been the major factors in the decline in rehabilitations. A major cause in the most recent drops in rehabilitations has been attributed to the loss of Social Security trust funds in the Beneficiary Rehabilitation Program for SSDI and SSI recipients.

The number of disabled persons rehabilitated rose from 291,000 in 1971 to 361,000 in 1974 but then declined to 277,000 in 1980. There has been a further decline to 255,000 in 1981 since the accompanying table was released by RSA.

There has been a steady increase in funds appropriated by Congress for rehabilitation programs since the late 1960s, but higher inflation rates and the recent revision of the Social Security BRP funding have eroded the buying power of those funds. For

instance, in 1981 there was a less than 1 percent decrease in available funds but the consumer price index increased 10.4 percent from the previous year resulting in a net decrease of 10.2 percent in real dollars. During that same time, cases served declined 5.2 percent and persons rehabilitated declined 7.7 percent.

Expected lifetime earnings of per-

sons rehabilitated and the ratio of lifetime earnings to the cost of rehabilitation also show a decline after several years of increase. Increased emphasis on the more severely disabled has been cited for the decline in these statistics.

—*Rehabilitation Review*, National Association of Rehabilitation Facilities.

A wheelchair hasn't kept Curtis from school, marriage, children, and a federal career spanning 34 years. She spent 19 of those years (1951 to 1970) as secretary to the late Mary E. Switzer, who championed vocational rehabilitation and causes of handicapped persons globally. Appropriately, Curtis' office is in the Mary E. Switzer Building.

**Rehabilitations and Cost Benefit Ratios
1971-1980**

FY	Rehabilitations	Expected Lifetime Earnings (in Thousands)	Total Costs (in Thousands)	Ratio
1980	277,136	11,535	1.106	10.4:1
1979	288,325	11,576	1.006	10.9:1
1978	284,396	10,890	1.005	10.8:1
1977	291,202	9,650	.954	10.1:1
1976	303,328	8,869	.815	10.9:1
1975	324,039	9,094	.802	11.3:1
1974	361,138	9,867	.748	13.2:1
1973	360,726	8,852	.652	13.6:1
1972	326,138	7,201	.538	13.4:1
1971	291,272	5,872	.480	12.2:1

Handicapped Employee Overcomes Barriers; Receives Cash Award

When Frances D. Curtis was stricken with polio at age 13, she didn't know what architectural and transportation barriers were. She does now.

To get a job in 1948, the Maryland resident had to be carried in her wheelchair up steps at the Federal Security Agency, later the U.S. Department of Health, Education, and Welfare.

There have been many barriers since, but Fran—as her friends know her—has consistently overcome them. For overcoming these barriers, there have been rewards. The latest is a \$5,000 cash award, which was presented to her by William Bradford Reynolds, assistant U.S. attorney general for civil rights at the Department of Justice, recognizing her outstanding performance as administrative officer of the U.S. Architectural and Transportation Barriers Compliance Board (ATBCB).

On her first job, Curtis played a major role in getting a ramp built and restrooms renovated at HEW's north building on Independence Avenue Southwest to make it more accessible to handicapped employees like herself.

Independent Living Book Is Available

The question about the role of independent living programs in serving people with mental retardation is addressed in the latest addition to the *Issues in Independent Living* technical report series produced by the Independent Living Research Utilization project of Houston.

"Independent Living and Mental Retardation: The Role of Independent Living Programs" features a definition of independent living as it pertains to mentally retarded people, as developed by authors Carol Siegelman and Jerry Parham. For persons with limited familiarity with the field of mental retardation, the authors provide a brief history of the movement and describe the present mental retardation service network, giving particular emphasis to services that pertain to independent living.

The authors discuss ways that service agencies, programs, and consumer organizations can collaborate to establish a division of labor that will result in a coherent network of alternatives.

To order, send a check or money order for \$5 to ILRU; P.O. Box 20095; Houston, Texas 77225. Allow up to 6 weeks for delivery.

Center Studies Management- Employee Relations

Fred Knubel

It is now commonly accepted: employees do not leave their home problems when they come to work, nor do they forget their work problems when they return home.

And at a time when trade unions face pressure for benefit "give-backs," workers worry about job security and managers grapple with the threat of a stubborn recession, the pressures of the modern-day work world grow.

That is why, says Sheila Akabas, director of Columbia University's Industrial Social Welfare Center, "we're riding a crest right now, a trend of interest in the work we're doing. The problems we deal with are more severe, the problems people have are more severe—and the possibilities for providing an important service through the workplace are increasing."

Dr. Akabas, professor in Columbia's School of Social Work, helped establish the research and training center in 1970. It was the first program in the United States to focus on developing mental health, social, and rehabilitation services in the workplace. Today its former students are employed as counselors in major industries, working with employees and managers and forging social services designed to help both.

The center has trained social workers to help emotionally troubled workers maintain satisfactory job performance, assist older workers to prepare for retirement and aid disabled workers to become rehabilitated. It has become the model for other programs at universities across the country.

"We felt this was a very fertile area," Dr. Akabas says, "but what has happened was beyond our imagination."

Starting 12 years ago as a 3- to 5-year project with a \$75,000 grant from the Rehabilitation Services Administration, Department of Health, Education, and Welfare, the program has established itself with a \$200,000 annual budget and ongoing funding from the National Institute of Mental Health, various foundations, private corporations, and trade unions.

Similar programs have sprung up at Arizona State University, Hunter College, Tulane University, the University of Pittsburgh, the University of Southern California, and the University of Utah.

Dr. Akabas calls the field "one of the growth areas in social work." In 1974 the Columbia School of Social Work placed "a handful" of students in internships in workplace settings; this year it placed 40. In 1978 a

national survey by the foundation-funded Industrial Social Welfare Project, based at the Columbia center, reported that there were 100 social workers at corporate or trade union workplaces around the country. Today, there are more than 500 and "new positions are opening faster than Columbia's center can track them down," Dr. Akabas says.

Students in the School of Social Work can receive both master of science and doctoral degrees with a specialization in industrial social welfare. Columbia is the first university in the United States to offer a doctoral specialization in industrial social welfare.

The program, Dr. Akabas says, was revolutionary at its inception. For years, work and the rest of life were seen by many as two separate worlds; work roles and other roles were commonly viewed by management and work institutions as unrelated. But in recent years women, minorities, and the disabled have brought new skills and new needs into the workplace, making new demands on employers and trade unions. "Social workers moved," Dr. Akabas says, "out of the agency mode and instead viewed the workplace as a system where over 100 million people collect each day. It has

an impact on people and their mental health, and is therefore an appropriate place to locate services."

The center is responsible for what Dr. Akabas calls "one of the most exciting" social service programs in the country, a cooperative venture with the University's School of Law that provides socio-legal services to 100,000 civil service employees and their families, through New York's District Council 37, the American Federation of State, County and Municipal Employees.

"We have service programs in many trade unions and corporations in New York City," Dr. Akabas says. "Our graduates are out working in family service centers in Ohio, with dock workers in California, and Navy personnel in Washington, and in major corporations across the country."

Conferences and training sessions are scheduled for managers and social workers nationwide. Programs involving mental health agencies and "the world of work" help to "improve the linkage," Dr. Akabas says,

"between public and private institutions."

Increased worker productivity, from lower rates of absenteeism, fewer accidents on the job, and improved morale, is the key result for industry managers. "We know that when workers perceive the workplace as a caring environment," Dr. Akabas says, "their morale improves."

Mr. Knubel is Director, Office of Public Information, Columbia University, New York City.

NY Organization Makes Big Apple Theatres Accessible

New York City now has a service to make its numerous theatre, music, and dance performances, both on and off Broadway, more accessible to disabled people.

The Theatre Access Project, funded through the nonprofit Theatre Development Fund with donations from Exxon and the New York City Council on the Arts, sells tickets (often with generous discounts) and provides the following services to disabled people—a large or regular type summary of the play and information about public transportation to the theatre, mailed with the tickets; seats reserved in the first 10 rows for persons with visual or hearing impairments; wheelchair locations, as well as aisle seats for persons using crutches or canes, or who can transfer from wheelchairs; a TTY for hearing impaired persons; seating charts to help locate the reserved seats; and ushers who are trained in sign language.

Since its inception in 1981, the Theatre Access Project has also pro-

vided sign interpretation for eight hit plays, including "The Elephant Man," "A Chorus Line," and most currently "Annie." A special team of two deaf people and an expert in sign language evaluate the signed performances for clarity.

For blind theatregoers, a special telephone "hotline" and audio cassettes describing the sets, costumes, and other visual aspects of the shows are in the works.

For more information, contact Ruth Cullen, Theatre Access Project, Theatre Development Fund, 1501 Broadway, New York 10036; (212) 221-1103, TTY 719-4537.

Book To Help Deaf Job Seekers Find Proper Work

Deaf and hearing-impaired people with solid job skills are sometimes frustrated in their job search or career advancement by a lack of job seeking information that is readily available to hearing people.

Deborah Veatch, an assistant professor at the National Institute of Technology (RIT), has written a job seeking guidebook specifically for the

deaf and hearing-impaired. *How To Get The Job You Really Want* offers step-by-step instructions for deaf and hearing-impaired people who are preparing to enter the job market, seek promotions, or change careers.

How To Get The Job You Really Want is a workbook that allows readers to learn through a variety of activities. It is written in easy-to-read language with illustrations to help the reader visualize the job search process.

The book describes job search decision making, resume development, employment letters, employment materials, sources of employment information, newspaper ads, job applications, employment interviewing, and starting a new job. It contains examples of cover letters, resumes, and other forms of business communication materials related to the job search process.

How To Get The Job You Really Want is available for \$10.95 plus \$2.50 postage and handling from: NAD Bookstore, 814 Thayer Ave., Silver Spring, MD 20910. Bookstores, schools, and organizations ordering more than five copies will receive a 20% discount along with NAD advancing members purchasing single copies.

Horticulture:

Hiring The Disabled

Charles Richman



Americans Reject Low-Image Work

In December 1982, *The Wall Street Journal* carried the following front-page headline: "‘Dirty Work,’ Americans turn down many jobs vacated by ouster of aliens . . . they disdain meager pay, low status of positions; a case of belittled pride." The article detailed efforts "Project Jobs" organized by the United States Immigration and Naturalization Service to oust undocumented workers from illegally held jobs. It was theorized that unemployed Americans would be eager to fill jobs (paying an average wage of \$4.81), if given the opportunity.

However, surveys in Los Angeles, New York, Houston, and Detroit soon showed this to be untrue. Followup interviews indicated that most of the vacated jobs were refused by American workers and once again filled by the arrested aliens or their counterparts. Nearly all of the U.S. workers who took the jobs only lasted a few days. The article notes: "Most of those interviewed say they spurned

the jobs mainly because they considered them dead-end, demeaning and underpaying . . . all say they believe Americans simply don't want such jobs (although some say they would reconsider if the pay were better)."¹

What are the reasons for this unexpected rejection of work during these days of double-digit unemployment? Some labor market experts attribute these job turndowns to today's worker expectations. Most children are not brought up to be manual and blue collar workers. Furthermore, the belief that hard work is a primary vehicle for upward mobility is in disrepute. Rising levels of education in the U.S. accompanied by rising occupational expectations may contribute to the phenomena.

One of the case histories detailed in the article described a \$4.20-an-hour tree-trimming job in Houston. After 2 weeks of climbing trees and hauling brush, a young Houston worker of 19 rejected the work. He had enough of working on the job, mainly because he was disturbed about working with Mexicans. A certain stigma is attached to work held by foreign laborers; this exemplifies the attitude "that this is the dirty work of society and that people born, brought up, and educated in the United States should not have to do them."

This reflects on a major manpower supply problem in the horticulture industry (and other unskilled and semi-skilled industries). There are thousands of such jobs which might fit someone's definition as being too dirty, too hard, or just plain unglamorous. Yet, these are often labor-intensive jobs which contribute to the economic wealth of our nation and to the livelihood of many millions of workers. Currently, few clients of state vocational rehabilitation agencies are entering into horticultural and agricultural jobs. Less than 3 per-

cent of all clients "closed rehabilitated" are eventually employed in such work. This represents the second lowest job placement category reported in state VR statistics.² This is the case despite the fact that hundreds of clients nationwide are involved in horticulture training and rehabilitation activities.

Beyond Horticulture Therapy

The use of horticulture as a therapeutic activity goes back thousands of years. Working in the soil and gardening have been prescribed by physicians as a treatment for mental and physical ills as far back as ancient Egypt. The little-understood curative effect of working with plants has been perpetuated today in hundreds of horticultural training and rehabilitation programs throughout this country.

They had their beginnings in the late 18th century when Dr. Benjamin Rush, a signer of the Declaration of Independence and professor of psychiatry, described the value of outdoor and gardening work. Many state mental institutions sought the therapeutic benefits of such treatment by establishing orchards, gardens, conservatories, and greenhouses during the next hundred years. "Gardening therapy," as it was called in the 1920's and 30's, was then recognized as an "adjunctive" to other recognized forms of treatment and therapy.

During the 1940's post World War II period, numerous new horticultural therapy programs opened and expanded in Veterans Administration hospitals. It was about this time that "horticulture therapy" became recognized as a distinctive discipline in its own right. Gradually, professional training courses developed and "horticultural therapists" gained recognition and stature. Today, the National Council for Therapy and Reha-

bilitation through Horticulture represents the profession with almost 850 individual and institutional members. At least nine universities offer degrees in horticultural therapy, while numerous courses are available through botanical gardens, community colleges, and universities.

Horticultural therapy and rehabilitation programs are operated in public and private institutions, state hospitals, schools, nursing homes, and rehabilitation facilities. Such prestigious organizations as the Institute of Rehabilitation Medicine-New York University Medical Center, the Meninger Foundation, and Clemson University have longstanding programs. A model freestanding horticultural training and rehabilitation program has been operated by the Melwood Horticultural Training Center in Upper Marlboro, Maryland for 20 years. This program has received international recognition and attention over the years.

Melwood operates as a horticultural business and operates a horticultural training, sales, and contracting program. Through sales of plants, ground maintenance services, nursery operations, and work cooperative programs, Melwood gains funds for self-support while offering training and employment preparation.^{3,4} However, despite the success of Melwood and other horticultural efforts, a gap has been perceived in the rehabilitation process. This gap occurs when jobs are sought for job-ready trainees in competitive employment once rehabilitation and training has concluded.

As has been noted in a recent article on vocational rehabilitation using horticulture: "There is an opportunity for employment as the horticultural industry does utilize semi-skilled or unskilled labor. However, to date, there has not been a concerted effort

to educate the horticultural and agricultural industry toward hiring the handicapped.”⁵ It is the need for qualified, competent, and motivated workers by horticulture employers, accompanied by the need to place trained and rehabilitated disabled workers, which led to a new approach to job development.

Horticulture Work

The horticulture industry is multifaceted, including retail, wholesale, production, and service components. It is the branch of agriculture which concerns itself with intensively cultivated plants used for food, aesthetic or medicinal purposes. Commercial aspects of the industry include:

- **Horticultural products**—the production of all horticultural crops, nursery and greenhouse products, garden supplies, sod, seed, plants, plant supplies, flowers, floral supplies; and,

- **Horticultural services**—the provision of all landscape, lawn and garden services, ornamental shrub and tree services, grounds maintenance, and services related to plant planting, care, and planning.

In the past few years, horticulture services have been the fastest expanding segment. Demand for these services has increased tremendously as sales of ornamental and environmental plants increased in supermarkets, department stores, shopping malls, and other retail outlets. The veritable explosion of home gardening and residential landscaping has created a service industry overnight.

Government estimates indicate that today there are at least 527 thousand workers employed in various aspects of the horticulture industry. It is projected that an additional 102 thousand workers will be added by 1990. Throughout the country there are some 30,000 florists; 46,000 land-

scape firms; 99,000 retail nursery, garden, and lawn suppliers; and 39,000 nursery and greenhouse suppliers.

Florists, landscaping firms, garden centers, grounds maintenance firms, and other horticulture activities are prevalent in every community and town. Many of these operate as small businesses. For example, some 98 percent of all retail nurseries, lawn and garden supply stores, and retail florists employ 20 or fewer employees. Yet, it is just these small businesses which create new jobs, not the large corporations and conglomerates. During the past 10 years, three-quarters of all new jobs created in our economy were created within small businesses.

Job opportunities exist today for gardeners and groundskeepers, arborists (tree specialists), orchard and vineyard workers, floral designers, salespeople, nursery workers, transport and equipment operators, etc. Horticulture jobs and careers are both numerous and diverse and dispersed in every town and geographic area.

Meeting The Need

It became clear to leaders in the field of the horticulture therapy movement that while horticulture business had difficulties in recruiting personnel, trained disabled workers were not being employed in great enough numbers. A successful model for accomplishing just this task is the Projects With Industry (PWI) approach. This 15-year-old program has permitted the Rehabilitation Services Administration to work closely with employers and their intermediaries. The approach involves a host of standard OJT, prevocational, and support service programs accompanied by a key ingredient—industry and business guidance and involvement.

Over the years, more than 50 PWI

projects developed as applications of the approach expanded. A number of the projects are industry-based such as those sponsored under the auspices of the Electronic Industries Foundation, National Restaurant Association, International Association of Machinists and Aerospace Workers, and the IBM Corporation. These projects concentrate on employment in a particular industrial or business segment or sector and use trade, association, or union sponsors to get the job done.

The Electronic Industries Foundation PWI Project has been particularly successful in its efforts at placement of workers in electronics work.⁶ They have successfully demonstrated an “industry-outreach model” for linking disabled workers with available electronic industry jobs. This has been described as “marketing” disabled workers to private employers while emphasizing their capabilities and minimizing their limitations. The model depends upon a process in which accurate and current labor market data is available; complete information on the disabled applicant’s capabilities is used; and a satisfactory match is made between the disabled worker and the job. It evolved and was modified over a 5-year period, and is described and documented in a project resource manual.⁷

This model became the basis for application to the manpower and placement dilemma encountered by the horticulture industry and horticulture therapy and rehabilitation programs. In the fall of 1982, “Horticulture Hiring the Disabled (Plants For People)” was awarded as a 3-year PWI grant under the U.S. Department of Education, Rehabilitation Services Administration. It is expected that, using an industry-based approach, over 160 disabled workers will be placed into horticulture work.



On page 20, a client at Melwood Horticultural Training Center in Upper Marlboro, Maryland receives instruction in floral arrangement. Above, David James (right), Director of Greenleaf Industries, takes time to give individual attention to handicapped nursery workers.

The project grant which was awarded to the National Council for Therapy and Rehabilitation through Horticulture has already received enthusiastic industry support. Groups such as the American Association of Nurserymen, National Food Processors Association, American Seed Trade Association, Florist Telegraph Delivery, Interior Plantscape Association, Professional Grounds Management Society, Ralston-Purina Company and Gerber Foods, Inc. are participating on the National Horticulture Industry Advisory Committee of the project. With their guidance

and assistance, the PWI model will be adapted to the characteristics of the industry and to its particular employment and labor recruitment needs.

This story began with the tale of work being rejected in this country. It is the aim of "Horticulture Hiring The Disabled" to remedy a pressing manpower problem of horticulture businesses. Jobs identified under the program may be difficult, some may be "dirty," yet all will provide good working environments for disabled workers. At the present time, plans are going forward to set up pilot projects in California, Florida, and Washing-

ton, D.C. The horticulture industry is being made aware of the capacities of disabled workers and their value as a stable and reliable labor source.

Mr. Richman is National Project Director for the Horticulture Hiring The Disabled (Plants For People) Project. For further information please contact him at: Horticulture Hiring the Disabled, 9041 Comprint Court, Suite 103, Gaithersburg, Maryland 20879.

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St. Paul Institute Provides Deaf People Post-Secondary Education

Theresa Monsour

About 20,000 children were born with hearing impairments during the mid-1960s because their mothers contracted rubella.

Now those children are reaching college age, and when they start thinking about where to go for a post-secondary education, many will look to St. Paul Technical-Vocational Institute (TVI), a major federally funded vocational program for the deaf.

Only 40 of 150 students enrolled in the program this fall are from Minnesota. The rest come from across the country to take classes ranging from auto mechanics to welding.

"We happen to be very, very lucky to have such a program right here in our own school system," said Henry Etten, a teacher in Highland Park Senior High School's program for deaf and hearing-impaired students.

Etten said it's "absolutely" more important for deaf and hearing-impaired people to continue schooling after high school than it is for hearing children.

"It's a push towards independence" he said, adding that schools and parents tend to shelter deaf children too much.

"They are going into a hearing

world, and that's the world they're going to have to learn to live in," said Donald McKoskey, St. Paul public schools rehabilitation consultant.

Since the deaf and hearing-impaired program started at St. Paul TVI in 1969, a total of 1,406 students from nearly every state and Canada have enrolled there, said program head Bob Lauritsen.

Jim Polzin, a 1980 St. Paul TVI graduate, came to the school from Chicago because it has the only tool-and-die program for the deaf. He now works for a Fridley company.

"It's really wonderful here," Polzin said.

Born deaf, Polzin's disability wasn't discovered by his parents until he was about 2. He said he had to pick up sign language from a friend when he was 10.

Polzin attended a public high school in Chicago, where the only special help he received was from a teacher who knew sign language and who conducted special tutoring sessions for the few deaf youngsters enrolled.

"I had never gone to a deaf school before, and I had never used sign language that much," he said. "TVI

was something new for me."

Georgia Jureski, 19, a St. Paul graduate of the Highland Senior High hearing-impaired program, enrolled in St. Paul TVI this Fall.

The petite woman said she considered becoming a model. But friends discouraged her, saying being hearing-impaired would be a big stumbling block to a successful fashion career.

"I'm interested in everything," she said, using sign language. "I don't know what I want to major in."

Many students attend only the preparatory program at St. Paul TVI, which lasts one quarter, and then transfer to another vocational school or a college.

The preparatory program is designed to help deaf and hearing-impaired students adapt to attending class in the hearing world, and to assist them in making a smooth transition to living alone.

Basics like handling a household budget and waking up on time are taught because many of the students relied on their parents to help them with such necessities.

Deaf and hearing-impaired students often are weak in areas such as literature and English because those subjects involve understanding words and abstract concepts, so remedial classes are taught in the preparatory program.

Also, the preparatory program helps students select a field of study.

Students try their hand at welding, engine repair, and other skills to determine where their skills lie. If they decide on a field not offered at St. Paul TVI, they can attend other area vocational schools that cooperate with the St. Paul school.

Youngsters who stay at St. Paul TVI take classes with hearing students. Classes are attended by sign language interpreters and notetakers, who de-

cipher complicated topics with drawings, graphs, charts, and symbols.

Tutors help deaf and hearing-impaired students conquer especially difficult concepts and subjects.

Auditory training is available to help students speak more clearly, read lips better, and improve residual hearing and the use of hearing aids.

Since most of the deaf and hearing-impaired youngsters are not from Minnesota, they need help socializing, Lauritsen said. The school offers a deaf students' club, a drama club, and a community athletics program.

Having a "critical mass" of deaf and hearing-impaired students makes them more comfortable, he said.

That "comfortable" feeling is evident in the deaf and hearing-impaired services office: office staff and counselors know sign language; the clerks and secretaries joke with the students; colorful posters and plaques decorate the room.

Lauritsen, who also is president of the Minnesota Foundation for Better Hearing and Speech, has a strong background in hearing-impaired issues. His parents were deaf and taught at the Minnesota School for the Deaf in Faribault.

His office is decorated with symbols of deafness, even though he can hear. A huge poster above his desk shows a child sitting in a chair making the sign for "I love you."

He's proud of the St. Paul TVI program, calling it a "modest investment" because deaf and hearing-impaired students trained there find jobs, pay taxes, and stay off welfare.

But such an extensive program doesn't come cheap. For the 1982-83 school year, St. Paul TVI is receiving \$631,880 in federal money for its deaf and hearing-impaired program. It also receives \$94,850 in federal funds for a special federal interpreter program.

The state provides \$40,000 for a more basic interpreter program. It also gives St. Paul TVI \$130,000 for its preparatory program.

Other post-secondary programs in Minnesota also receive some federal or state funds to run limited programs for deaf and hearing-impaired students.

Normandale Community College in Minneapolis specializes in helping deaf and hearing-impaired students improve their skills in the basics, such as grammar, spelling and math, said Dinah Patrykus, handicapped services coordinator there. About 15 hearing-impaired students are enrolled.

The University of Minnesota has had a formal program for deaf and hearing-impaired students for about four years. It offers counseling, interpreters and notetakers. About 40 students are enrolled.

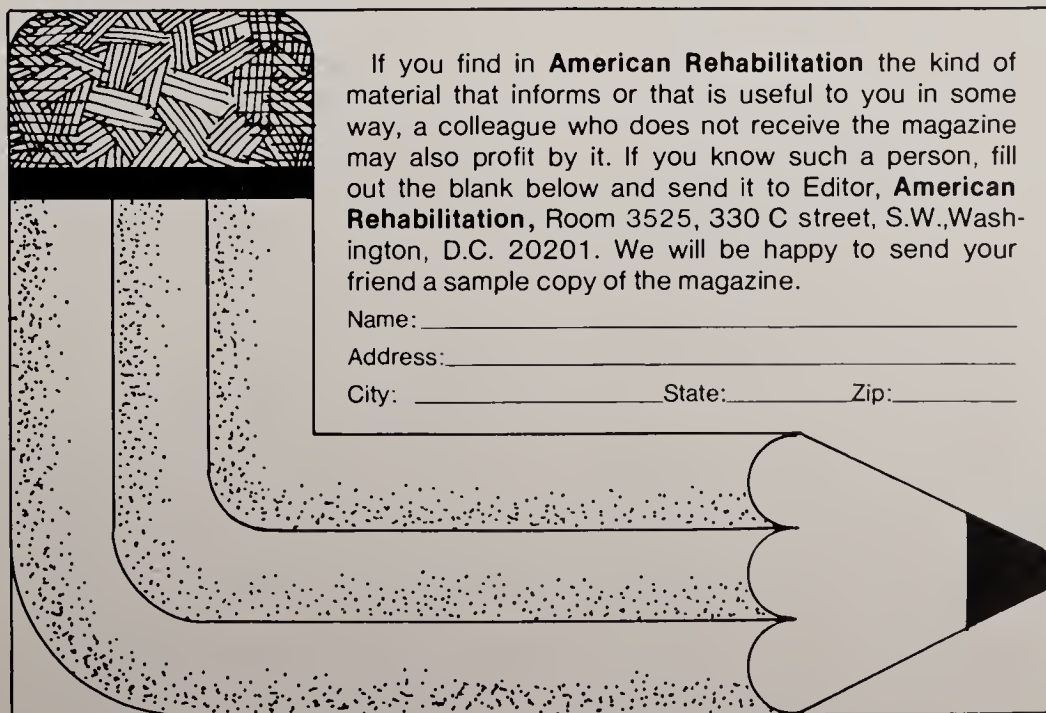
St. Mary's Junior College in Minneapolis specializes in training deaf and hearing-impaired students in nursing, occupational therapy, physical therapy, medical records technology, and medical lab technology. About 10 deaf and hearing-impaired

students are enrolled in the program.

Some Minnesota deaf and hearing-impaired students attend Gallaudet College in Washington, D.C., the first of six federally funded post-secondary programs for the deaf and hearing-impaired. The others are St. Paul TVI; the National Technical Institute for the Deaf in Rochester, N.Y.; California State University at Northridge; Delgado Junior College in New Orleans; and Seattle Community College in Seattle.

In 1975, Congress established regional education programs for deaf and other handicapped post-secondary students. The four regional programs that were selected—Delgado Junior College, Seattle Community College, St. Paul TVI, and California State University at Northridge—were guaranteed federal funding. That will expire in 1983, however, unless Congress decides otherwise.

Ms. Monsour is a staff writer on the *St. Paul Pioneer Press* in which this article appeared on September 19, 1982. It is reproduced here with permission of the *St. Paul Pioneer Press*.



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Name: _____
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Independent Living In Minnesota

Don Bania of Golden Valley, Minnesota, is now leading the active life he only dreamed about years ago when he was living in his parents' home.

The 30-year old quadriplegic fills his days with painting, attending church, bible study, visiting friends, and supervising the business end of his growing greeting card company which features his own mouthstick-painted artwork.

He credits his sense of independence and freedom to pursue his opportunities in part to his living in the one-year old Courage Independent Living Home, located near Courage Center, a United Way-affiliated rehabilitation organization in the Minneapolis suburb of Golden Valley.

"It's the little, simple adaptations in the house that allow me such freedom of movement," he said. "I've become more independent than I ever thought I could be."

The Courage Independent Living Home was built by Courage Center one year ago to serve as a working laboratory, demonstrating how innovations in structural design and adapted household devices could make single family living possible for people with physical disabilities. The home was designed by Roger Johnson-James Forberg Associates/Architects, Minneapolis, with the assistance of Courage Center's rehabilitation services staff. The facility was built by the M.A. Mortenson Company, Minneapolis.

Bania and two other young quadri-

plegics, Martha Donnelly, Short Hills, New Jersey and Charles Smith, Minneapolis, who has since moved into another accessible house, moved into the home in February 1981 with a married couple who serve as their personal care attendants. Over the past year, they have shared the home's facilities and, through their day-to-day activities, tested the practicality of its state-of-the-art design and equipment.

Original design features of the home include a two-van garage with power door; kitchen with accessible appliances and adaptive controls; adjustable counter tops; emergency medical alert system; pass card access exterior doors; light pressure "rocker" light switches; adapted "flip-up" door lock handles; two sun decks and a patio; wheel-in shower; whirlpool bath; three bathrooms with accessible sinks and toilets; adjustable shelving and lowered clothing rods in closets; fire alarm system and a heated, ice-free entrance walkway.

In addition, the home was built with a broad southern exposure to take advantage of passive solar heat, and can be remodeled for an "active" solar heating system.

Adapted living devices in the home include an intercom, central environmental control system, "easy-open" window handles, an elevated writing desk with "lazy susan" shelf and a telephone device that automatically calls the operator, who can then dial the desired number.

The home was also intended to be an educational resource for individuals wishing to learn more about accessible housing. An "accessibility resource room" is filled with literature and examples of adapted living devices, much of which is available free of charge to families, architects, builders, and other rehabilitation professionals interested in household accessibility. Public tours of the home are conducted on Wednesdays throughout the year.

According to Barb Scharff, the Independent Living Home Manager, over 340 people toured the home through June 1982.

"Our visitors fall into three categories," Scharff said. "They are people who want to learn how to remodel an existing home to be more accessible, those who want to build new accessible homes or architects and health professionals who want to learn more about accessibility in general."

Scharff added that since the home opened, much new equipment has been added, including a new burglar alarm, lamps that can be operated by simply touching their pedestals, and bumper guards on door frames and wall corners. The Courage Center staff is also working with a local window company to see if the home's windows can be designed to open and close automatically.

Scharff says that in a year's time she and the residents have learned which of the home's devices are prac-

tical and which need to be modified or discarded.

"We are continuing to look for a type of power door that is reliable and can be used by disabled individuals easily," she said. "We're also trying to modify the elevator door so it can be opened more easily by people with limited use of their hands."

"But that's one of the reasons we built the home," she added. "We

want to learn what works, what doesn't, and what needs to be adapted so it can aid a disabled person in self-sufficiency."

When asked if she thought the home was achieving its purpose, Scharff replied, "I think our experiment is working, just from the sheer number of visitors and inquiries we have received."

Bania seems to agree.

"In the future, if I can afford to build my own home, I hope to incorporate as many features of the home as possible," he said. "It has boosted my self-sufficiency."

For information about the Courage Independent Living Home, contact the Administrator, Courage Residence, Courage Center, 3915 Golden Valley Road, Golden Valley, Minnesota 55422, 612-588-0811.

Researchers Develop Electronic Leg Controlled By Thought

An artificial leg with an electro-mechanical knee that operates by the will of the wearer has been developed by a team of researchers at Moss Rehabilitation Hospital, Philadelphia. The leg is believed to be the first of its kind for use by people with above-the-knee amputations, according to Gordon D. Moskowitz, Ph.D., senior research scientist of the hospital's Rehabilitation Engineering Center. Dr. Moskowitz and his colleagues reported on their work at meetings held in September 1982 by the IEEE Engineering in Medicine and Biology Society and the Alliance for Engineering in Medicine and Biology.

Dr. Moskowitz explained that the leg is set in motion when the wearer either consciously or subconsciously sends signals to the muscles above the amputation site. A computer connected to electrodes on the thigh senses the electrical activity of remaining musculature. The resulting patterns of electrical activity about the leg are analyzed by a program which signals the leg to react. A pneumatic tube actuator provides the

energy that enables the movement to take place.

Because the leg is controlled by the will of the wearer, it can be sensitive to unexpected occurrences that can affect gait and cause stumbling, such as bumps in sidewalks or high curbs. The natural motion of the leg enables the wearer to simulate closely his or her normal gait and to lift and cross the limb in a smooth action, Dr. Moskowitz said.

Initial work on the leg began more than 3 years ago. Studies by the engineering team on an amputee showed that the muscles above an amputation site remain active after the limb has been removed. By analyzing muscular activity at the hip and thigh, the researchers were able to recognize a reliable pattern that the upper leg muscles follow when the knee is willed to flex or extend and thus move the lower leg. In addition, they were able to show that a portion of the energy dissipated could be recovered and later used to create motion.

Building on this information, the researchers fashioned a prototype for a volitionally-controlled electro-mechanical leg that has been successfully tested on one amputee.

The leg is currently tied to an external mini computer. Ultimately Dr. Moskowitz expects the device to contain its own micro-computer and a

hydraulic rather than pneumatic actuator. An ultra-light plastic prosthesis developed at Moss Hospital will provide a natural-looking enclosure for the knee.

The research team hopes to develop a clinical model of the leg within 3 to 5 years.

The Rehabilitation Engineering Center at Moss Rehabilitation Hospital is one of 17 centers funded by the National Institute of Handicapped Research to combine engineering in a university laboratory setting with clinical care in a rehabilitation institution. The Center at Moss operates in conjunction with Drexel University and Temple University School of Medicine.

New Technique For Restoring Speech Described

Thanks to advances in reconstructive techniques, patients whose larynxes have been removed because of cancer may regain the ability to speak. But until now, the main complication resulting from this type of surgery—aspiration (food or liquid traveling down the trachea into the lungs)—has been largely unconquerable and has

(Continued on page 30.)

Language Used or Used Language?

Obfuscation is a term that defines the art of utilization of many big words on the pretext that these words say a modicum of truth to the world in which we live. Not true!

In March 1979, we wrote in this column: "What we would like to see is an integration of language use in all courses along with a continuation of intensive and specific English courses. It should not be sufficient for a math student to get the right numerical answers, but he should be able and required to express those conclusions clearly in the mother tongue. His reports in later years, after all, will require this."

An article by James Lardner in *The Washington Post* (August 17, 1982), "The Rebirth of Writing," expounds this theory in reporting on a National Writing Project that seeks to "make students approach writing differently by making teachers approach it differently." But the article goes on to say that a consensus has built "around the untraditional notions: that students should get beyond the model of 'academic writing' with mere correctness as its goal; that they should write in all classes, not just in English. . . ." In so doing, he reports on programs at the City University of New York, University of California at Berkeley, George Mason University in Virginia, Howard University in the District of Columbia, and the University of Maryland, among others. At George Mason, a Writing Across the Curriculum program prods non-English teachers "to require routinely much more writing from students."

We anxiously await seeing the re-

sults. In the meantime, to the effort we say, "All Hail . . ."

Superabundance. Sue these words for nonsupport.

Is a *correspondence producer* identical to a writer? The former expression takes 22 characters, the latter 6!

"He is required to take a volunteer or work experience position." To volunteer or to work is an "experience," and they are both "positions." Those kinds of sentences make about as much sense as saying, "He went to work at working his work." This author (we believe) wanted to say: "He is required to volunteer or get a regular job."

". . . to be far beyond his capabilities." Beyond capability is out of reach by any means, so "far" beyond makes about as much sense as "near" beyond.

Current trend. Defined, a trend is "a general or prevailing tendency or course, as of events, a discussion, etc." so that a trend is allowed as present unless identified (by a disclaimer) as events from the past or likely to occur in the future.

". . . a grant *has been prepared* and is now in the final stages of review." We cannot see how it could be reviewed without having been prepared. The same holds true for this phrase from the same paper: ". . . *has prepared* and *will have available* for distribution soon a listing . . ." How about "will soon distribute" with the

idea already in place that if it will be distributed it was prepared and certainly is available!

"Letters have been sent to *all* unsuccessful applicants." "All" is not at all necessary or needed, for that matter.

Careful Writing. Simple writing does not necessarily mean clear writing.

"The establishment and *successful* operation of a program depends on its clear-cut philosophic premise . . ." We become more and more convinced that most writers could benefit by weighing what they say, by placing each word on the scale to see if it might be overbloated or hollow. To understand the uselessness of *successful* in the above sentence, place it also before "establishment"—it makes as much sense! The word is really superfluous and is made even more ridiculous here by its placement in only one term of the compound subject. Since the sentence intimates success in its simple structure, it simply is more successful without its use.

Bureaucratic Bias (*Good words that become vogue, and consequently, vague.*) Component. ". . . head winds no longer delay commercial airliners. Head wind components do," observes Edwin Newman in his book, *Strictly Speaking*. The practice increases, and its continuance leads to such expressions as "its component parts," which is to say, "its parts parts." (Unless we are truly speaking of the part's parts—which is infrequently the case—the use is redundant.)

From a high official's letter: "Anyone wishing to express their own views . . ." "Anyone wishing to express his (or her) views," expresses our view since the pronoun now agrees with its reference (anyone) and the removal of "own" agrees with the possessive "his" (or "her").

Rehabilitation Engineering Helps Many

A lot of people appreciate modern technology for making difficult tasks easy; others appreciate it for making easy tasks possible. Many of those in this latter group are people who are benefiting from the work of rehabilitation engineers.

Rehabilitation engineering is a relatively new field concerned with improving the quality of life for people with physical disabilities by applying modern technology to their particular problems and needs.

One such person whose quality of life is on the upswing is 15-year-old Jim Grimm of Center City, Minnesota. Jim is quadriplegic from severe athetoid cerebral palsy. Because of cerebral palsy, he is unable to vocalize, and the only voluntary muscle he can consistently control is his tongue.

Although Jim has attended mainstreamed public school classes since first grade with the help of a management aide, communication has always been a problem for him. About a year ago, Jim and his parents enlisted the help of the Communication Resource Center and rehabilitation engineer Ray Fulford at Courage Center in Golden Valley, Minnesota.

The Center's rehabilitation engineering department devised a tongue-operated switch for Jim that is held in place with a chin strap. The tongue device is essentially an on-off switch, and Jim spent a summer practicing Morse Code with the switch hooked up to a beeper. Later, the device was connected to an Apple computer, and

Jim now communicates by scanning words and letters and printing out his choices on the computer's monitor.

The computer does double-duty at home where he studies with educational software programs and at Chisago Lakes Junior High where he is taking an advanced mathematics course. Courage Center's rehabilitation engineers hope to get Jim to use a double switch that will speed up his input process and expand the possible uses of the computer. Later, a portable monitor can be attached to Jim's wheelchair, and eventually a voice synthesizer may be incorporated into the system.

The rehabilitation engineering field has been around for 10 or 12 years, according to Fulford, and was spawned from the work done during the 1960s by technicians who were working on artificial limbs and other prosthetic devices. Most rehabilitation engineering work being done today is in the area of research and is being conducted by 18 major university-affiliated programs located throughout the United States.

Research efforts are generally devoted to specific areas of engineering, such as development of prosthetic devices, wheelchair design, automobile adaptations for disabled drivers, communication devices for people with vocal impairments or special seating and support systems for people with neuro-muscular problems who develop complications in posture or sores from being sedentary

for long periods.

It was not until about six years ago that direct client services such as those offered at Courage Center started popping up. These engineering services for individual consumers have been slow to establish themselves because of the difficulties in securing funding for them.

The uniqueness of Courage Center's program lies in the fact that engineering services are offered in conjunction with comprehensive physical rehabilitation services. The Center's rehabilitation engineering department consists of an engineer, an electro-mechanical technician and a cadre of volunteers (most of whom are retired engineers from Honeywell with upwards of 30 years experience each).

Rehabilitation engineers provide their technical expertise to other programs at Courage Center such as the occupational and speech therapy departments.

In therapy, computers are used primarily with clients who have had head injuries, a disability group that has drawn attention lately because of their growing numbers and the lack of specialized programs for them. Although the use of computers for therapy is in an experimental stage, the computers should prove valuable in cognitive re-training. Re-training often involves repeating an exercise over and over again, and computers have a unique capacity for repetition of instructions and tests.

Courage Center's engineers specialize in nonvocal communication adaptations, workplace accommodations and residential independent living devices. Some of the innovations to come out of the Center's consumer-oriented service are: a dressing device that helps people who have limited movement in their upper extremities dress themselves, computer keyboard masks for people whose spasticity makes it difficult for them to hit only one key at a time, and a floppy disk handler developed for Control Data Corporation that allows a person with minimal manual dexterity to unload and load the fragile magnetic disks used as information storage devices in many small computer systems.

NEW TECHNIQUES

(Continued from page 27.)

caused many of these patients to develop pneumonia.

Although previous attempts to create a valve that would eliminate this problem have failed in the majority of cases, a team of researchers at the New Jersey Medical School, Newark, think they may have found the answer. Reporting at the 68th annual Clinical Congress of the American College of Surgeons, Stuart M. Greenstein, M.D. described a new technique that has been successful in the canine model and that he and his colleagues believe may solve the problem of aspiration in humans.

According to Dr. Greenstein, the researchers created a fistula, or opening, between the trachea and esophagus; such an opening is necessary for phonation, or the ability to speak. A piece of skin from the neck was used to cover the tracheal stump and served as a one-way valve, which permitted air to flow up from the lungs for

speaking but prevented food from traveling down the trachea.

"The flap acts like a flutter-valve," Dr. Greenstein said. "It opens only when the pressure from below is great enough for the patient to speak."

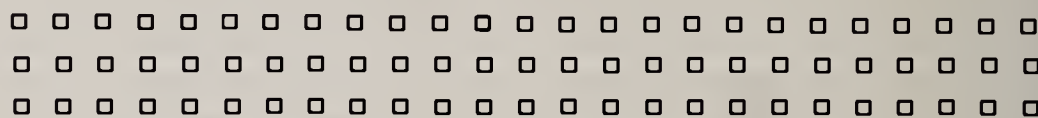
The new technique, which was performed on eight dogs, was considered successful only if there was no aspiration. Achieving phonation alone was not considered adequate, Dr. Greenstein said. The desired results were achieved immediately in five of the dogs. The other three dogs showed signs of aspiration and underwent a second operation to have their skin flaps revised.

According to Dr. Greenstein, successful phonation and prevention of aspiration depends on four factors—air pressure, air flow, flap size, and

flap resistance. "These factors must be considered before construction of the neolarynx," he said, adding that "if the flap should shrink during healing and not cover the opening properly, we can reconstruct it to the right size."

On the basis of their successful experience with dogs, the New Jersey Medical School researchers anticipate that the technique soon will be used in human patients.

Dr. Greenstein said that people should understand that reconstructed speech is not the same as normal speech. "There's a discernible difference," he added. "It's usually much hoarser." He added that the researchers hope to refine the flap so that a distinction can be made between male and female voices.



Survey Finds Easy Accommodations by Companies

Washington, D.C. — The September-October issue of *In The Mainstream* reports on a Department of Labor-funded survey of 2,000 private industry federal contractors which shows that those employers who make accommodations for their handicapped employees feel such modifications are usually inexpensive and "no big deal."

The 20-month study is the first national survey on employers' efforts to accommodate their disabled workers. It was conducted for the Labor Department by Berkeley Planning Associates and Harold Russell Associates (subcontractor).

According to the newsletter article, the survey found that eighty-one percent of the accommodations made cost \$500 or less; fifty-one percent cost nothing. Seventy-nine percent of

the companies did not think accommodations are "prohibitively costly."

Other findings include:

- Most firms felt the accommodations were successful in helping their disabled employees be effective in their jobs.

- The range of accommodations made by employers included structural modifications in the plant affecting all workers and specific accommodations which were undertaken for particular workers in their jobs.

- A major factor encouraging a company to make accommodations is the affirmative action commitment of its top management.

For a copy of the September-October issue of *In The Mainstream*, send \$5.00 to Mainstream, Inc., 1200 15th St., N.W., Washington, D.C.

AMERICAN REHABILITATION

Author Listing

Volume 8, Numbers 1-2, 1982

Bendel, Judith G.	Sept/Oct	20	La Rocca, Nicholas G.	Nov/Dec	9
Brown, Dale	Nov/Dec	23	Majumder, Ranjit K.	Sept/Oct	26
Brubeck, Thomas	Sept/Oct	10	Misra, Sita	Sept/Oct	26
	Nov/Dec	19	Molinaro, Dave	Sept/Oct	4
Hammond, Norman	Nov/Dec	3	Mullins, June B.	Sept/Oct	20
Holland, Nancy J.	Nov/Dec	9	Shui-Fong, Sarah Poon	Sept/Oct	14
Kaplan, Irwin	Nov/Dec	3	Sommers, Paul A.	Nov/Dec	28
			Tseng, M.S.	Sept/Oct	26

AMERICAN REHABILITATION

Content Listing

Volume 8, Numbers 1-2, 1982

ADMINISTRATION

Patient Education For Cord Injured	Sept/Oct	20
Classifying VR Program/System Indicators	Sept/Oct	26
Managing Med Care For Children With Chronic Disabling Conditions	Nov/Dec	28
The LD Adult: Administration Challenge	Nov/Dec	23

ARCHITECTURAL BARRIERS

View From The Castle	Nov/Dec	19
----------------------	---------	----

AUTOMATION Projects With Industry

COUNSELING Vocational Adjustment in Multiple Sclerosis	Nov/Dec	9
--	---------	---

DISTRICT OF COLUMBIA

New Facility In D.C.	Sept/Oct	12
View From The Castle	Nov/Dec	19

EMPLOYMENT

Projects With Industry	Nov/Dec	3
Vocational Adjustment In Multiple Sclerosis	Nov/Dec	9

EVALUATION

Classifying VR Program/System Indicators	Sept/Oct	26
Managing Med Care For Children With Chronic Disabling Conditions	Nov/Dec	28

FACILITIES

New Facilities In District of Columbia	Sept/Oct	12
Association Aims To Integrate Disabled	Sept/Oct	14

Patient Education For Cord Injured	Sept/Oct	20
Vocational Adjustment In Multiple Sclerosis	Nov/Dec	9

Managing Medical Care For Children With Chronic Disabling Conditions	Nov/Dec	28
--	---------	----

HONG KONG Association Aims to Integrate Disabled

Sept/Oct	14
----------	----

INTERNATIONAL Association Aims To Integrate Disabled

Sept/Oct	14
----------	----

LANGUAGE

Language Used Or Used			PREVENTION State of Art:		
Language	Nov/Dec	8	Infant Services	Sept/Oct	10
Language Used or Used			PROJECTS WITH INDUSTRY		
Language	Sept/Oct	9	Projects With Industry	Nov/Dec	3
LEARNING DISABILITIES			RECREATION View From the		
The LD Adult: Administrative			Castle	Nov/Dec	19
Challenge	Nov/Dec	23	TRAINING		
MULTIPLE SCLEROSIS			Education Via Satellite	Sept/Oct	4
Vocational Adjustment In			Patient Education For Cord		
Multiple Sclerosis	Nov/Dec	9	Injured	Sept/Oct	20
NEW YORK Vocational Adjust-			WEST VIRGINIA		
ment In Multiple Sclerosis	Nov/Dec	9	Education Via Satellite	Sept/Oct	4
PLANNING			Classifying VR Program/System		
The LD Adult: Administrative			Indicators	Sept/Oct	26
Challenge	Nov/Dec	23	YOUTH		
Managing Med Care For Children			State of the Art: Infant Services	Sept/Oct	10
With Chronic Disabling			Managing Med Care For Children		
Conditions	Nov/Dec	28	With Chronic Disabling		
Classifying VR Program/System			Conditions	Nov/Dec	28
Indicators	Sept/Oct	26			

Spinal Cord Injury Statistics. John S. Young, Peter E. Burns, A.M. Bowen, and Roberta McCutchen, with an introduction by J. Paul Thomas. Spinal Cord Injury Statistics, Good Samaritan Medical Center, 1130 E. McDowell Road, Suite A-7, Phoenix, Arizona 85000-2675. 154 pages. \$25.

The Rehabilitation Services Administration began developing a Regional Model Spinal Cord Injury System in 1970. Seventeen systems ultimately were sponsored, and this book reflects their experiences from 1973 through 1981.

In 1975, the National Spinal Cord Injury Data Research Center was established at Good Samaritan Medical Center, to collect and analyze standardized data supplied by the regional systems. Data for over 6,000 cases were prospectively reported, providing information on the demography, etiology, and medical/social outcomes of spinal cord injury. Data were obtained for 6 years following injury.

A major portion of the statistical information produced by the project

is presented here. This book is designed as a reference for those who have an interest in, and responsibility for, the care of the spinal cord injured.

Independent Living With Attendant Care. Set includes "A Guide For The Person With A Disability" (20 pages), "A Guide For The Personal Care Attendant" (24 pages), and "A Message To Parents Of Handicapped Youth" (12 pages). ILRU, P.O. Box 20095, Houston, Texas 77225. \$3.50 each or \$10.50 for set.

As the individual titles indicate, different aspects of attendant care are explored, but the focus is upon effective working relationships rather than on tasks to be performed.

While their intended audience is obvious, the set could be of interest to people working in the program and other rehabilitation professionals and agencies.

Rights of Passage. 3/4" U-matic, 1/2" Beta or VHS. Objectif, P.O. Box 4743 Berkeley, California 94704.

(Study guide included.) Color. 58½ min. Rental, \$75 per day; sale, \$395 and \$5 shipping and handling.

"An unusually frank, aggressive, and effective use of video to present handicapped individuals demanding their rights to be independent, to be human, and to have equal access to those opportunities available to the nonhandicapped . . . technically and stylistically superior to most," *Choice Magazine*, American Library Association.

Handbook For Job Placement Of Mentally Retarded Workers. Third Edition. Angeline M. Jacobs, Judith K. Larsen, and Claudette A. Smith. The Ware Press, P.O. Box 397, Cambridge, Massachusetts 02238-0397. 324 pages. \$27.95.

This book's purpose is to facilitate integrating mentally retarded people into the competitive world of work. It presents sections on the mentally retarded worker, prevocational evaluation and training, vocational training, placement procedures, and job profiles.

COMMENTARY

(Continued from Cover II.)

or she" all the time. Of course, I understand why he or she doesn't. I wouldn't either.)

Allow me to illustrate my irritation by referring to the offering in your September-October issue. To begin with, it is ironic that a passage from the writing of Beth Heistand should be chosen to make a point about language usage. Her language is as "rough" as any I have encountered lately. For one thing, her writing would make good grist for the column's "Super-abundance" mill. For example: "Decremental budgeting is *really* my favorite one." As opposed to being her favorite one, but *not* really? Or, "I wonder how many people know that the *actual* definition of decremental is . . ." As opposed to what, the *potential* definition?

However, the use of words guilty of "nonsupport" is not the only problem with Ms. Heistand's writing. Notice how, from the fact that the definition of "decremental" refers to decrease in quality OR quantity, she infers that the term "decremental budgeting" refers to "budgeting less AND in a substandard way." Sloppy, sloppy, sloppy! She must have flunked elementary logic. Then there is the horrendously awkward construction of the sentence which refers to a "development that I've observed and was aptly described by Orwell in 1984." Ugh!

Next, I would point out that the perceptions of the column's author seem to differ markedly from my own regarding the "support" offered by certain words in certain contexts. For example, on my job I *work with* just about everyone on the staff, but I *work closely* with only a few. Believe me, there is a difference!

All *visits* are not necessarily *site*

visits. I always thought part of the purpose of a *site* visit was to inspect an agency's physical facilities. One can visit an agency without such an intention, can't one?

Yes, I have heard of steps that weren't *significant*. I am taking steps to encourage the writer of one of your columns to shape up. One step was to belly up to the typewriter. A significant step? Hardly. In fact, none of the steps I am taking are significant to any worthwhile objective.

Many attitudes, far from being *hard-boiled*, are as fluid as the tides of change.

In most argument, the vast majority of points which are made are peripheral to the overall debate, and only a few are key points. I have even known writers to make points which were totally *irrelevant* to the issue in question. By golly, I think I have even done it myself from time to time.

I would guess that of all the advice which has ever been given in the history of the universe, less than three-tenths of one percent has been *timely*. Most advice is based on hindsight, which is never timely.

This happens to be election day. The outcome of the various elections will be determined as much by those who do not vote as by those who do. Wouldn't you agree that the role taken by the non-voters is not an *active* role, but rather a *passive* role?

With regard to the Garfield bit, I would point out that any *ingratiation* in this context would be Garfield's and not the author's. Someone should let the author know that ingratiation is not the same as gratitude. Sloppy, sloppy, sloppy! And by the way, Jon's proper response to Garfield's question, "You mean there are amateur psychiatrists?" would be: "You 'blank-blank' right there are! The woods are full of them, notable among them, Jim Davis."

Finally, it is very clear to me that the expression, "Do you *see* what I am saying?" means the same as "Do you *understand* what I am saying?" This latter expression makes perfect sense to me. Am I aberant?

My recommendation to the author of your clever little column: Physician, heal thyself! Timely advice? Gee, I don't think so. **Carl W. Olson**, Public Information Officer, Nebraska Division of Rehabilitation Services for the Visually Impaired.

Taking an active role as an amateur (would be, that is) psychiatrist, I make a significant step in noting the key points of your timely advice about your displeasure with Ms. Heistand, Mr. Jim Davis, and the author of our language column. We hope that printing your letter brings a measure of ingratiation, but we can't promise anything less than a continued hard-boiled attitude about slovenly language.

Only one defensive (key) point: When I have lunch with my boss in the cafeteria, am I eating *closely* with him since I am eating *approximately* with some of the other diners and eating *minimally* with those who are furthest away? Do you understand what I am saying? **Editor.**

TOPIC OF STATE

(Continued from page 2.)

ments as it is for sighted people. According to Hubbard, "They (visually impaired persons) can be trained in much the same way as sighted pupils and, therefore, face a realistic work situation."

It must be working. The overall placement rate for graduates of the SDC Program stands at 80 percent.

—*Rehab Review*, California Department of Rehabilitation.

April-May-June 1983

AMERICAN

REHABILITATION



Food S...
For
Han...appod

The "Baby Doe" Case

George F. Will

WASHINGTON—The baby was born in Bloomington, Indiana, the sort of academic community where medical facilities are more apt to be excellent than moral judgments are. Like one of every 700 or so babies, this one had Down's syndrome, a genetic defect involving varying degrees of retardation and, sometimes, serious physical defects.

The baby needed serious but feasible surgery to enable food to reach its stomach. The parents refused the surgery, and presumably refused to yield custody to any of the couples eager to become the baby's guardians. The parents chose to starve their baby to death.

Their lawyer concocted an Orwellian euphemism for this refusal of potentially life-saving treatment—"Treatment to do nothing." It is an old story: Language must be mutilated when a perfumed rationalization of an act is incompatible with a straightforward description of the act.

Indiana courts, accommodating the law to the Zeitgeist, refused to order surgery, and thus sanctioned the homicide. Common sense and common usage require use of the word "homicide." The law usually encompasses homicides by negligence. The Indiana killing was worse. It was the result of premeditated, aggressive, tenacious action, in the hospital and in courts.

Such homicides can no longer be considered aberrations, or culturally incongruous. They are part of a social program to serve the convenience of

adults by authorizing adults to destroy inconvenient young life. The parents' legal arguments, conducted in private, reportedly emphasized—what else?—"freedom of choice." The freedom to choose to kill inconvenient life is being extended, precisely as predicted, beyond fetal life to categories of inconvenient infants, such as Down's syndrome babies.

There is no reason—none—to doubt that if the baby had not had Down's syndrome the operation would have been ordered without hesitation, almost certainly, by the parents or, if not by them, by the courts. Therefore the baby was killed because it was retarded. I defy the parents and their medical and legal accomplices to explain why, by the principles affirmed in this case, parents do not have a right to kill by calculated neglect any Down's syndrome child—regardless of any medical need—or any other baby that parents decide would be inconvenient.

Indeed, the parents' lawyer implied as much when, justifying the starvation, he emphasized that even if successful the surgery would not have corrected the retardation. That is, the Down's syndrome was sufficient reason for starving the baby. But the broader message of this case is that being an unwanted baby is a capital offense.

In 1973 the Supreme Court created a virtually unrestrictable right to kill fetuses. Critics of the ruling were alarmed because the Court failed to

dispatch the burden of saying why the fetus, which unquestionably is alive, is not protectable life. Critics were alarmed also because the Court, having incoherently emphasized "viability," offered no intelligible, let alone serious, reason why birth should be the point at which discretionary killing stops. Critics feared what the Indiana homicide demonstrates: The killing will not stop.

The values and passions, as well as the logic or some portions of the "abortion rights" movement, have always pointed beyond abortion, toward something like the Indiana outcome, which affirms a broader right to kill. Some people have used the silly argument that it is impossible to know when life begins. (The serious argument is about when a "person" protectable by law should be said to exist.) So what could be done about the awkward fact that a newborn, even a retarded newborn, is incontestably alive?

The trick is to argue that the lives of certain kinds of newborns, like the lives of fetuses, are not sufficiently "meaningful"—a word that figured in the 1973 ruling—to merit any protection that inconveniences an adult's freedom of choice.

The Indiana parents consulted with doctors about the "treatment" they chose. But this was not at any point, in any sense, a medical decision. Such homicides in hospitals are common imprimatur. There should be interesting litigation now that Indiana courts—whether they understand this or not—are going to decide which categories of newborns (besides Down's syndrome children) can be killed by mandatory neglect.

Hours after the baby died, the parents' lawyer was on the CBS Morning News praising his clients' "cour-

(Continued on Cover III.)

AMERICAN REHABILITATION

Volume 9, Number 2. The weakest ink is better than the strongest memory.

Apr-May-Jun 1983

-
- | | | |
|---|---|-----------------------|
| 3 | Model Spinal Injury Systems Program Results:
Implications For Service Delivery | J. Paul Thomas, Ph.D. |
|---|---|-----------------------|
-
- | | | |
|----|---|-------------------------|
| 11 | Treatment For The
Chemically Dependent | Bobbie J. Atkins, Ph.D. |
|----|---|-------------------------|
-
- | | | |
|----|----------------------------------|--------------------------------|
| 16 | Staffing Food Service Operations | A. Philip Nelan, F.S.C., Ph.D. |
|----|----------------------------------|--------------------------------|
-
- | | | |
|----|--|---------------|
| 22 | Life Enhancement At Vinland
National Center | Joyce A. Weil |
|----|--|---------------|
-
- | | | |
|----|--|-------------------------|
| 24 | National Institute of Handicapped Research
A Plan For Handicapped Technology Evaluation | James B. Reswick, Sc.D. |
|----|--|-------------------------|
-
- | | | |
|----|-------------------|-----------------|
| 28 | Companion Program | Marcia J. Gayle |
|----|-------------------|-----------------|
-
- | | | |
|----|-------------------------|----------------|
| 30 | Blind Woman Of The 80's | Eunice Fiorito |
|----|-------------------------|----------------|
-

DEPARTMENTS

- | | | | |
|----|----------------|--------|------------------|
| 2 | Topic of State | 23, 29 | Report Resources |
| 21 | Commentary | | |

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Paid subscriptions are accepted (see Cover IV for blank). Correspondence concerning paid subscriptions should be sent to Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

TOPIC OF STATE

Computer Training Has 3-Way Benefits

The innovative computer training program operating out of the Westside Center for Independent Living (WCIL) in Los Angeles graduated its first class of 26 students on May 25, 1982. These graduates, who came to the program from as far away as San Diego and San Luis Obispo, are now qualified to compete for entry level data programming positions on the same footing as any other applicant.

The 12-month training program was a cooperative effort between WCIL, Rehab, and a Business Advisory Council (BAC) composed of data processing executives from major Southern California corporations. Among these are Security Pacific Bank, Northrup Corporation, Arco, Southern California Edison, Ralph's Groceries, Southern California Gas, TRW, Xerox, and IBM. This Advisory Council gave approval to both the curriculum and hardware used in the training, to assure that it would be relevant to the needs and applications actually in use. They will also assist in job placement efforts for the graduates.

Rehab offered support and appropriate client referrals to the program. In remarks at the graduation ceremony, Dave Tegan, BAC chairperson and Robert Taylor, Project Director, gave Rehab a lot of credit for the success of the project. WCIL's Larry Bender was quoted as saying, "very simply, without the Department there would not have been any program. . . ."

The success of this program is particularly exciting for a number of reasons. First, it provides entry into well-paying jobs with real futures. Then, the heavy involvement of the business community assures that the training is appropriate to their needs and assures a higher level of placements. Also, the program is set up in such a way as to become eventually self-sufficient through placement fees generated by this year's graduates being plowed back into support of next year's.

So far, nine graduates have been placed in jobs, and the project's BAC is committed to placing the others. Anyone interested in more information on this highly successful project can contact Bob Taylor at 213/473-1240 (Voice) or 477-5306 (TDD).

—*Rehab Review* California Department of Rehabilitation.

Client Assistance Projects To Receive More State Funding

The Rhode Island Client Assistance Project (CAP) recently began its sixth year at Vocational Rehabilitation. Since the inception of the program, CAP has grown to realize the importance of educating clients and applicants about VR in addition to advocacy. As a result of their awareness of their rights and responsibilities, clients learn they must play an active part in their rehabilitation. CAP provides policy interpretation and information on agency procedures as well.

During the FY 1982 program year, CAP served 1,071 clients and applicants of Vocational Rehabilitation. In addition to continuing to review ineligibility determinations, the staff assists VR with annual reviews of sheltered employment cases, and has

extended its services to include clients of the Rhode Island State Services for the Blind and Visually Impaired.

Arts Integration Project Underway In Rhode Island

Vocational Rehabilitation, in cooperation with the Rhode Island State Council on the Arts (RISCA) and several service agencies, recently joined forces in an effort to implement a new grant from the National Committee—Arts for the Handicapped (NCAH). The national grant, supplemented by a special grant from the Rhode Island Development Disabilities Council, requires that the grantee (in this case, RISCA) develop state-wide, year-round programming which integrates disabled and nondisabled persons.

The overall goal of NCAH is to "assure that disabled individuals have equal opportunities to participate in programs which demonstrate the value of the arts in the lives of all individuals".

Specifically, the Rhode Island grant will provide for an "Artsreach" coordinator who will: 1) assist in awarding mini-grants to organizations which initiate innovative, integrated arts programs, 2) identify Rhode Island artists who are disabled, and 3) coordinate a "Very Special Arts Festival" which will bring creative work of disabled Rhode Island artists into public view. Vocational Rehabilitation Administrator, Edward J. Carley, has appointed Carl Barchi, Client Assistance Project Director, to assist RISCA with the "Artsreach" program.

Rehabilitation In Rhode Island, R.I. Vocational Rehabilitation.

MODEL SPINAL INJURY SYSTEMS PROGRAM RESULTS

J. Paul Thomas, Ph.D.

• *Patients with Traumatic Spinal Cord Lesions Now Live Longer than a Generation or so Ago.* During World War I, the average life expectancy was 6 to 12 months postinjury. The average was approximately 2 to 3 years postinjury in World War II. Now, life expectancy is not decreased significantly for patients who receive prompt, adequate care, such as that provided by the Rehabilitation Services Administration, Model SCI System Program.

• *A Spinal Injury, Particularly in the Upper Spine, is a Severe Catastrophic Injury that Affects most Bodily Organ Systems and Requires Treatment and Rehabilitation by a Variety of Specialists.* Information in the National SCI Data Bank indicates a large proportion of the spinal cord injured suffer major associated injuries.

• *The Ratio of New Paraplegics and Quadriplegics (SCI Categories) has Changed over the Last Decade from 65-35 Percent, Respectively, to 50-50.* Now, many SCI centers are experiencing 65 to 70 percent quadriplegics in their new patients. The National Data Base indicates 53 percent rate of quadriplegics over all years of data collection.

Based on the RSA-supported study conducted at Phoenix's Good Samaritan Hospital, and on the expert opinion of insurance industry representatives, the lifetime care costs for an average quadriplegic is estimated to be \$450 to \$600 thousand. This figure is based upon an average age of 31 years at time of injury, with and additional conservative life expectancy of

The enormous economic demands, as well as the social impact made on society as a whole by the lifetime care needs of persons with spinal cord lesions, have long been recognized by the medical and rehabilitation communities throughout the world. Compared with other types of neurological conditions, the costs are significantly greater. In the United States alone, approximately 8 to 10 thousand new spinal cord injuries occur yearly. The prevalence of spinal cord injury (SCI) in the U.S. is estimated to be between 150 and 200 thousand with the annual care cost exceeding \$3.4 billion.

The apparent discrepancy between the relatively low number of cases and the estimated high cost of patient care is attributable to such major factors as:

• *SCI Occurs in a Young Population.* Rehabilitation Research indicates that 80 percent of spinal cord injuries occur in the 15 to 30 age group. In a survey at the Texas Institute of Rehabilitation and Research, the average age of over 700 new SCI patients was 25. In the 17 Model SCI Systems, the average age was 28, which included patients injured in industrial accidents for which the average age was 40.

20 years or 50 percent of the normal additional life expectancy. Because of lower costs for initial hospitalization, attendant care, and medical complications, the lifetime care costs for a paraplegic are estimated to be \$280 to \$350 thousand.

Perhaps more important than the costs of disability is the loss of independence and reduced quality of life. Rehabilitation workers around the world have long recognized spinal cord injured patients as a special challenge to their professional capabilities and patience. More than any other disability, spinal cord injuries cause catastrophic physical and psychological problems that augur rehabilitation failure. All too often, such patients spend months in hospitals, followed by the rest of their lives in nursing homes.

Generally, spinal cord injured patients are not rapidly referred for rehabilitation; many hospital staffs are not experienced or equipped to handle them; and, continuing medical complications prevent effective rehabilitation planning. Consequently, only a small number achieve the level of self-sufficiency, family participation, and vocational success that they deserve.

Model System Concepts

After extensive review of several SCI conference reports, RSA proposed a model to Congress and the rehabilitation field. The model provides for rapid case finding and referral; early rehabilitation coordinated by a highly sophisticated team; a mechanism for using all the necessary community agencies and services to facilitate rehabilitation success; and a long term community followup program to ensure that gains and adjustments are maintained.

In June 1970, the Good Samaritan Hospital in Phoenix was awarded an RSA research and demonstration grant that brought together the resources of the Spinal Cord Injury Service of Good Samaritan Hospital, the Barrow Neurological Institute of St. Joseph's Hospital, the Arizona State University, the Arizona Division of Rehabilitation, and the air evacuation and emergency medical programs of the Arizona State Highway Patrol.

Since then, RSA has supported 16 additional model SCI systems on a research and demonstration basis. Besides measuring and analyzing the effectiveness and costs of the Model System approach, these projects also evaluate regional or local variations and modifications in SCI service delivery.

In 1978, Congress provided legislation in Sect. 311(b)(1) of the Rehabilitation Act authorizing the continued development of the Model Systems. The Model Systems concept embodies the following objectives:

- To establish, within a catchment area or region of natural patient flow, a multidisciplinary system of providing comprehensive rehabilitation services to meet patient needs from point of injury (emergency treatment and transportation) through acute

care; rehabilitation, including vocational and education preparation; community and job placement; and long term followup.

- To achieve new knowledge through research in reducing disability and treating SCI and its complications.

- To demonstrate and evaluate the development and application of improved methods and equipment essential to the care, management, and rehabilitation of the SCI patient.

- To demonstrate methods of community outreach and education for the spinal cord injured in housing, transportation, recreation, employment, and other community activities.

Model System Components

Range of Services. A spinal cord injured person—regardless of the source of economic sponsor—requires a comprehensive, multidisciplinary, balanced continuum of service covering all phases of care and rehabilitation from the point of injury, or disability, through successful long term community adjustment. The following range of services must be included:

- *Emergency Services and Acute Care:* This includes evacuation and transportation, as well as emergency and early acute care (1-10 days post onset).

- *Rehabilitation Services:* Physical restoration (10-120 days post onset), vocational/educational preparation (should be initiated during care), plus community placement and adjustment must be provided.

- *Long Term Comprehensive Followup:* This includes medical, social, psychological, and vocational followup on a regularly scheduled basis.

Accessibility of Care. The accessibility of care (including the identification of persons with recently incurred spinal cord injuries) through a well de-

veloped, emergency evacuation and transportation subsystem that must include a network linking transportation units in the field through a coordinating focal point to the designated and emergency and acute care medical facility or facilities. The transporting agency must have: personnel who are trained in proper handling and evacuation of SCI and severely traumatized persons and evacuation personnel who are under medical supervision during patient transport.

Coordination of Services. Effective coordination of services includes the appropriate program advocacy administered and guided by a lead physician who has recognized, specialized training and experience in rehabilitating spinal cord injured patients during the early care phase of rehabilitation, plus an allied rehabilitation professional to serve as coordinator during the vocational and placement phases.

Patient Volume. An adequate and substantial volume of patients is necessary to support a Model SCI System demonstration project. For a 20-40 dedicated bed SCI Program, a minimum of 50-70 new cases a year must be available. Prior rates of case identification, admissions, readmissions, and discharges are used to evaluate this requirement.

Clinical Research/Evaluation. The interest in, and environment for, clinical research and evaluation also affects program effectiveness. This requires sophisticated data collection, retrieval and analysis capability for each subsystem as well as the total system collectively. Cost effectiveness and systems analysis studies will evaluate the benefits of the various subsystems and the total system in terms of regional variations and differences in project structure and design.

Other Components. A high-quality relationship, including the sharing of medical and allied rehabilitation staff

by the acute medical care and rehabilitation services, is necessary for rehabilitation plan development, research collaboration, and training.

Realistic training opportunities must be available for specialists in the various disciplines involved in the rehabilitation of persons with spinal cord injuries.

Appropriate agency liaison, plus effective public and community education programs, is needed to decrease the incidence of traumatic spinal cord injury (prevention).

carefully defined, indepth protocols. The "common data base" must be limited to objective data, documenting such things as demography; epidemiology; and medical, social, and vocational events, over time, following injury.

Reaching a consensus of the Model Systems Representatives as to which variables were to be included in the common data base was a tedious process. However, that was only the beginning. The next chore was to write a syllabus carefully defining

date of injury, covering the events of the year reported. The first followup year covered only the time between the initial discharge data and the first anniversary date of injury. There was considerable variation in this period, ranging from 8 months to zero.

In addition to the followup "Form 11," a separate report was submitted for each hospitalization occurring in the reported years. All cost variables required actual charges be documented with appropriate bills and invoices. This imposed a tremendous

... the Queen's English, particularly when written by Americans, is fraught with potential misinterpretation or multiple interpretation.

Results of the National Data Base

The original Model SCI System Data Base consisted of 472 variables designed to answer major, if not all, of the medical, social, vocational, and economic questions of interest to the multiple disciplines involved with the spinal cord injured. Many medical specialties, in particular, were interested in acquiring statistical information based on their clinical contributions.

During the course of several conferences held in Houston (1972), Chicago (1973), Washington, D.C. (1974), and Virginia (1975), a common data base was tediously and arduously developed. Research questions were defined. Some were specifically clear, while others were somewhat ambiguous. Data to answer these questions were selected on the basis of collectibility, reliability (objectivity), and relevance.

The process of variable selection was haunted by the realization that pooled data on all patients must of necessity be standardized and, as a consequence, would be relatively superficial. Specific clinical questions relating to the efficiency of therapeutic techniques would have to await

each variable so that there would be a standardization of data originating from multiple sources. In concept, it seemed simple. However, the Queen's English, particularly when written by Americans, is fraught with potential misinterpretation or multiple interpretations.

The final syllabus was drafted, report forms were designed, and the reporting methodology field tested by a few centers. Finally, data reporting commenced. Additional conferences of data collection representatives were held annually over the first few years of operation to iron-out deficiencies in the reporting mechanism so as to enhance data quality control.

Currently, the National SCI Data Bank contains prospective information on 6,014 SCI cases, collected over the period 1973-1981. At the time of initial discharge, a "Form 1" was submitted (covering the demography of each case along with the events of the injury and subsequent hospitalizations leading to initial discharge). This has been labeled the initial Medical/Rehabilitation ("injury-to-home") Period.

Subsequently, a "Form 11" was submitted annually on the anniversary

chore on data collection personnel. However, a respectable 80 to 90 percent reporting of known, actual values was achieved for most cost variables.

Demography

Incidence. The data collection methodology used by the National Spinal Cord Injury Data Research Center (NSCIDRC) was not designed to provide statistical data necessary to establish the true incidence of traumatic spinal cord injury (SCI) in the United States. Reported cases were those admitted to the Regional SCI Systems. Unfortunately, the population at-risk from which these cases were drawn is unknown.

Excluding the cases of immediate, or early death, the incidence of spinal cord injury for those cases surviving the initial injury and admitted to a hospital was 32.2/million population. This survival group compares well with those of other epidemiological spinal cord injury studies.

The current estimates are quite adequate to define the magnitude of the problem for service planning purposes. Suffice to say that the annual incidence of spinal cord injury in the

United States is approximately 52 per million population but only 32 per million survive to require medical and rehabilitation services. Thus, the United States can anticipate between 7,000 and 8,000 new traumatic spinal cord injured survivors each year.

Neurological Impairment. There are many degrees of neurological impairment among persons with spinal cord injury. In general, the higher the injury to the spinal cord, the more extensive is the paralysis and the loss of sensation. Further, the spinal cord may be incompletely damaged at the site of the lesion. As a result, some sensory and motor stimuli may still pass to and from the brain to bodily structures below. The degree of such incompleteness may range from a few surviving neural fibers to almost com-

ple, complete and incomplete. These neurological categories are used consistently throughout this statistical report.

The number of paraplegics is only slightly less than the quadriplegics (47 to 53 percent). Complete injuries are considerably more prevalent in paraplegics (60 percent) while incomplete injuries occur slightly more frequently in quadriplegics (52 percent).

Age at Injury. Spinal cord injury occurs predominantly in younger people. The average age at onset for all cases is 28.7 years. Fifty percent of the injuries affected individuals below 25 years. The most common age is 19. Traumatic spinal cord injury is rare in children under age 14, but a noticeable increase occurs at age 16, probably associated with the attain-

ment of the legal driving age. Almost half of the injuries occurred in the 15 to 24 year age group.

Occupational Classification. Working people are more likely to be injured off the job than on-the-job. The most dangerous categories are agriculture, structural work, and the miscellaneous category. The first two of these present a high risk with 34 percent of cases injured on-the-job. Those in the miscellaneous category fare worse, with 43 percent of the cases in this group injured on-the-job. These rates are considerably higher than the next group, technical/professional workers, which had 25 percent of the job-related injuries. The group least likely to be injured on-the-job appears to be benchworkers, who account for nine percent of the injuries.

There are pronounced differences in the etiology of job-related injuries among the different occupational categories. Vehicular accidents are no longer the major cause in all groups. Fifty percent of all cases in the service category, which includes law enforcement and security guards, were victims of penetrating wounds. Falls are the predominant cause of injury

Traumatic spinal cord injury is rare in children under age 14, but a noticeable increase occurs at age 16, probably associated with the attainment of the legal driving age.

plete and incomplete; and, paraplegic preservation of all fibers coursing through the injured area. Major differences can be found in the extent of preserved neurological function in persons with incomplete injuries at identical levels of the spinal cord. Of course, persons with complete spinal cord injuries have a complete loss of sensation and voluntary muscle control below the level of their injuries.

Because of the high variability in level and extent of neurological impairment, subcategories are useful in providing populations which are more homogenous with respect to neurological loss and, conversely, preserved useful muscular or sensory function. Clinical experience and statistical analysis have identified four major categories—quadriplegia, com-

ment of the legal driving age. Almost half of the injuries occurred in the 15 to 24 year age group.

Occupational Status at Time of Injury. Sixty percent of injured per-

for 4 of the 10 categories, while falling/flying objects are also quite common causes of on-the-job injuries. Falls and falling/flying object injuries are actually more frequent than are vehicular injuries for job-related injuries. This represents the combined effects of a higher age group, safety regulations, and undoubtedly, sobriety. As expected, sports injuries and penetrating wounds are found less often among these cases. Vehicular accidents are twice as prevalent in the nonjob related injuries. Injuries as a result of falls occur three times as often as being hit by a flying or falling object and are 27 times more frequent in the work-related group.

Etiology

Specific Causes of Injury. Automobile accidents are by far the most frequent cause of spinal cord injury (38 percent). Falls or jumps are the second major source of SCI (16 percent) with gunshot wounds third (13 percent). The latter is a phenomenon unique to the United States in the Western World. Considering the relatively small population at-risk, motorcyclists appear to be particularly vulnerable to spinal cord injury. Driving injuries are not only a major cause of spinal cord injury, they are characterized by a high percentage of complete quadriplegia. Most result from horse play and injudicious behavior. Cases reported to the National Spinal Cord Injury Data Bank are estimated to represent approximately 10 percent of the spinal cord injuries that occurred in the United States in 1973-1981.

Distribution of Etiology by Age Group. The data clearly reveals that the 15-29 year age group is most at-risk for each of the etiology categories. Aside from this, several other features may be observed. The heaviest concentration of injuries for

Considering the small population at-risk, motorcyclists appear to be particularly vulnerable to spinal cord injury.

the 15-29 age group is in the sports categories. About 80 percent of those cases are due to sports related injuries. The next most frequent age for sports injuries is the 30-44 year group and the less-than-15 year group.

An intermediate concentration of cases occurs (between 60 and 70 percent) in the 15-29 year age group for vehicular and penetrating wound injuries. The next most common age group for both types of injury is the 30-44 year group, followed in turn by the 45-59 year group. Children, however, are almost equal to the 45-49 year olds in the frequency with which they suffer penetrating wounds. Both of these etiologies, as well as the sports injuries, are almost nonexistent in people over 59 years of age.

The smallest number of injuries in the young adult age group is found in the falls and falling/flying object categories. These injuries are spread much more evenly across all ages than are other injury types. Injuries due to falls extend into the oldest age groups. This might be expected as a result of the increasing degree of skeletal frailty and other infirmities of old age.

Falling/flying object injuries are commonly work-related and should show the observed association with the working years. The corollary of this is also seen with very few such injuries in the very young and very old age groups.

Medical

The total management of spinal

cord injury includes not only treatment of the spine and its neural contents, but also associated injuries and subsequent medical complications. Spinal cord injury often occurs as a result of high-velocity accidents inflicting multiple associated injuries. Profound disturbances of the endocrine, automatic, neuromuscular, and neurosensory systems predispose the spinal cord injured to a wide variety of medical complications.

The grim implications of lifetime paralysis tend to focus the attention of the initial treating surgeons on the preservation of neurological function. They must, however, be keenly aware that the total function of the injured individual will depend on how successfully the multiple clinical problems arising from other injuries, occurring at the time of the accident, and subsequent medical complications, are recognized and treated. The purpose of this section is to document the broad spectrum of injuries and medical complications encountered in the management of spinal cord injury. Cases are limited to those admitted to a SCI System within 24 hours of injury to achieve maximum reporting accuracy.

Major Medical Conditions Existing at Time of Injury. Spinal cord injured people may have pre-existing major medical conditions which adversely influence their state of health following injury. In some instances, the medical and social problems typically associated with spinal cord injury are compounded by the impact of

these pre-existing conditions. Since spinal cord injury occurs predominantly in the younger age groups, pre-existing medical conditions are relatively rare. However, when such conditions are present, they present major medical problems.

Persons with alcoholism, drug dependency or mental disorders have difficulty coping with additional psychological and physical stress imposed by spinal cord injury. In all probability, these conditions have been under-reported in this study.

Respiratory problems, such as asthma and emphysema, contribute to morbidity in the spinal cord injured. The data pose an interesting research question. What changes, if any, occur in the medical management regimes of the epileptic, asthmatic, and cardiac following spinal cord injury—both in the acute and chronic phases? The incidence of pre-existing spondylitis, spinal anomalies, and curvature is high and probably represents a predisposition to spinal cord injury.

Associated Injuries. In the National Data Base, a multiple of diagnostic codes are used to describe the injuries which occur at the time of injury. Many of these are minor and add little to the overall clinical management problem. Some associated injuries, though severe, were excluded from this study because they occurred only a few times in a large number of cases.

The incidence of selected major associated injuries was carefully analyzed. The paraplegia injuries are ranked in order of the frequency of their occurrence. It is readily apparent that associated injuries are markedly more prevalent in paraplegia. The categories of injury are not mutually exclusive. An individual patient may have any combination of injuries (i.e., closed rib fractures, long bone fractures, and a major head injury),

Driving injuries are not only a major cause of spinal cord injury, they are characterized by a high percentage of complete quadriplegia.

but is counted only once in each category. Of interest is the fact that skull fractures were more frequent in paraplegia than in quadriplegia. The high incidence of injury to the visceral organs and intrathoracic organs in paraplegics reflects not only the results of the large external forces necessary to cause spinal fracture in these regions, but also because penetrating wounds most frequently occur at thoracic levels.

Medical Complications. The data presented are relevant to medical complications occurring during the initial treatment of the injured individuals. This treatment may extend over an average period of approximately 5 months.

The incidence data of selected major medical complications was collected. Leading the list for both paraplegia and quadriplegia is urinary tract infection. The reporting criteria for this diagnosis require that all cases of bacteriuria be coded as urinary infection. In many cases, a low-grade infection that does not constitute a clinical problem is present.

Pressure sores were the second most common complication. The incidence of thrombosis and phlebitis reported is suspiciously low and probably represents incomplete recognition and recording of this diagnosis. Published studies, using multiple diagnostic techniques or autopsy data, have established the incidence of thrombophlebitis in spinal cord injury at a much higher level (65 to 85 percent). The striking feature of these data is the high incidence of compli-

cations involving the cardiovascular and pulmonary systems. As with the associated injuries, any combination of these complications may be present in an individual patient, culminating in a complex problem of multisystem management.

Operative Procedures. Orthopedic procedures were the most common. Forty percent of all cases had spinal fusion. Twenty-four percent had open instrumentation with and without reduction (codes 81.5 and 81.6). Open reduction without internal fixation was rarely done. Laminectomy was performed on 19 percent of the cases.

A clear picture of the occurrence of surgical procedures performed on spinal cord injury patients during their initial hospitalization is given. All surgical specialties are represented. Orthopedic procedures are by far the most common, followed by neurosurgery, abdominal surgery, and urological surgery. The data support the concept that the modern spinal cord injury center must have all surgical specialties readily available.

Urinary Management. An association exists between the level and degree of paralysis and the level of urinary management attained by the spinal cord injured following injury. The method of urinary management was studied for paraplegics and quadriplegics with different levels of neurological function at discharge from initial hospitalization.

Better urological function is associated with the lower levels of injury and incomplete lesions. Only 20 percent of the complete paraplegics de-

pend on indwelling catheters compared with 38 percent of the complete quadriplegics. A low percentage of both neurological categories with useful motor function used catheters. Over 40 percent of both paraplegics and quadriplegics with motor useful function achieved normal micturition.

Considerably fewer quadriplegics were maintained on intermittent catheterization than paraplegics, possibly because quadriplegics have limited and suppler extremity function which makes self-catheterization difficult.

As an incidental finding, a pronounced shift between the use of an indwelling catheter and intermittent catheterization in the Regional SCI Centers occurred over the past decade. The data well documents the decline in cases discharged with indwelling urethral catheters and the rise in the use of intermittent catheterization during the years 1973 through 1980. The limited clinical data in the National Data Base does not permit analysis as to the effect this transition has had on morbidity and mortality resulting from urological causes.

Independence in Functional Activities. Dependence on others for assistance in daily activities is markedly greater in the quadriplegic group. It is also inversely related to the degree of preserved neurological function. With the exception of walking, a high percentage of paraplegics are able to become completely independent. Walking appears to be realistic in only the motor functional paraplegic group. Among the quadriplegics, only the motor functional group has a reasonably high percentage of cases that achieve independence in functional activities. Quadriplegics with preservation of sensation only and nonfunctional motor power appear to do only slightly better than those with complete injuries. The same is true of the

paralegics but to a lesser degree. In both paraplegics and quadriplegics, little difference is noted between complete injuries and those with preserved sensation only.

Sixty percent of the paraplegics with useful motor function were able to walk. When these were separated from those in that same category who could not walk, they showed a considerably higher percentage of independence in almost all daily living activities. The nonwalkers' activities were similar to the nonfunctional motor group.

Forty-seven percent of the motor functional quadriplegics were able to walk. When these were separated from the nonwalkers, they showed a level of independence which was almost as high as the motor functional paraplegics who could walk and the nonfunctional motor group.

Annual Incidence of Selected Medical Complications. The reported annual incidence of selected medical complications in the years following injury was studied for cases that were hospitalized and not hospitalized, respectively. Urinary complications lead the list. Spasms are also a frequent complication. The hospitalization group has a considerably higher rate of pulmonary conditions and a higher reported incidence of many other conditions. Most probably this results from the fact that hospital diagnoses usually are of a more serious nature and are better reported and documented. Of interest is the low incidence of phlebitis in chronic spinal cord injury.

Summary

The medical management of spinal cord injury is a complex, multidisciplinary challenge. Acute patients almost routinely have multiple trauma resulting from high-velocity injuries. Subsequent to their injury, they are

prone to develop medical complications involving all the major body systems, particularly the cardiopulmonary, urinary, and vascular systems. The medical and surgical management of these complex cases requires a highly coordinated program involving a variety of medical, surgical, and allied health professionals.

In addition to their basic professional skills, each member of the treating team must have specific clinical experience in spinal cord injury. Spinal man presents unique problems in diagnosis. Symptoms may be whimsical and are frequently masked or distorted by sensory impairment. Profound disturbances of reflex mechanisms controlling the automatic, nervous, and endocrine systems require modification of the standard surgical and medical regimes used in treating spinal intact man. Special considerations enter into surgical decisions. Anesthesia is never routine.

Medical management requires special skills from physicians, nurses, respiratory therapists, urological technicians, and other professionals. Diagnosis and treatment of medical conditions that do arise require the close collaboration of specialists orchestrated by a primary physician who specializes in the treatment of spinal cord injury.

All of these requirements are best achieved in a coordinated Spinal Cord Injury System which includes (properly trained and equipped) emergency medical services, a neurotrauma center, a spinal cord injury rehabilitation program, and appropriate psychosocial and vocational services to provide for return to the community and productive living with an aggressive and effective followup program.

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NARIC Publishes Subject Catalog

The National Rehabilitation Information Center (NARIC) announces the availability of its latest publication, *REHABDATA: A Selective Subject Catalog*. NARIC is a research utilization project funded by the National Institute of Handicapped Research (NIHR, contract #300-83-0006). The catalog is designed to help the rehabilitation community to easily and quickly access information from NARIC's rehabilitation research database—REHABDATA. It is a print version of selected database contents for 1976-1981.

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Efficacy Of Combined Treatment For Chemically Dependent People

Bobbie J. Atkins, Ph.D.

Alcohol and polydrug abuse does not appear to be declining in the United States. People who suffer from these diseases have traditionally been thought of as moral degenerates, derelicts, and morally weak. (It was only recently that the American Medical Association recognized addiction as an illness.) Therefore, for many years, alcoholics and drug abusers received limited treatment in their placement in psychiatric institutions or incarceration. Their recidivist rates were high.

Alcoholics Anonymous (AA) was founded in 1935 by alcoholics exclusively to treat alcoholism. Similarly, such groups as Narcotics Anonymous (NA) and Synanon were developed for the drug abuser. These separations were necessitated by client needs for identity and treatment. In addition, governmental agencies furthered this separation when they were established to delegate and monitor separate treatment programs for alcoholics and drug abusers.

Since the American Medical Association now lists alcoholism and drug abuse as illnesses and the American Psychiatric Association categorizes alcoholism and drug abuse as behavioral disorders, the current focus is away from psychiatric disturbance. For example, some states have eliminated from their statutes public drunkenness laws, offering hospitalization as an alternative to incarceration.

While the scene is changing, group separation continues, as does treatment.

Alcoholics and drug abusers are not purists. Typically, if the abusers cannot obtain their supply of alcohol or drugs, they will use a substitute. Since there is much mixing of drugs, treatment personnel may find other addictions in addition to the primary chemical of abuse. The question becomes, "Should the other addictions be left untreated and the program focused only on the primary drug?" Hence, funding and health planning agencies have requested that treatment personnel deal with the dilemma of separate versus combined services.

Some treatment hospitals have combined treatment of both groups, occasioning the term "chemically dependent" to describe the broader category. This treatment model focuses on the person rather than on the primary chemical involved.

The treatment model has been debated for sometime. As expected, some authorities stress group similarities while others stress differences. Unfortunately, concrete evidence is short on both sides and the issue remains unresolved. Hence, before a merged model can be accepted as preferred, investigators must present concrete evidence regarding similarities among alcoholics and drug abusers.

This paper addresses a study whose

focus was on identifying similarities and differences among alcoholics and drug abusers, comparing them on the basis of age, marital status, and personality trait factors on Cattell's Personality Factors Questionnaire (16 PF). Logically similar group findings would imply combined treatment efforts while dissimilarities would favor separate treatment.

Literature Review

Treatment for alcohol and drug abusers was originally offered in the field of mental illness. Two separate institutes (The National Institute on Alcohol Abuse and Alcoholism [NIAAA] and the National Institute on Drug Abuse [NIDA]) set policy, oversee regulations and accountability, and channel money through their respective programs and agencies. Although they remain separate, the tendency among treatment providers is to combine alcohol and drug abusers in a single program, which tends to be less expensive and more representative of the community.

In reviewing the literature on combined programming, there seemed to be more advocates of this approach than opponents. Nevertheless, some authorities oppose combined treatment, citing characteristics that differ for the two groups as reasons for maintaining separate treatment programs. For example, drug users tend to be younger, more frequently from lower

socioeconomic levels, minority group members involved in illegal activities, and aggressive personality types, while alcoholics tend to be middle-aged, family men, employed, and passive personality types.^{1 2 3} Lief⁴ and Pittman⁵ stated that because of these differences, alcoholics and drug abusers should be treated separately. Combined programs, they say, probably would not meet the varied needs of such diverse patients.

Kissin argued for constituting treatment groups based on such variables as age, sex, ethnicity, and lifestyle, but not necessarily based on the substance abused. He pointed out that programs treating both groups together are successful when there is a homogeneity of population and that the least important aspect of the program is the commonality of addiction.

The literature developed by advocates of combined programming can be divided into three categories: philosophical, clinical or experimental, and ex-post facto studies. The philosophical category should begin with a statement made by the World Health Organization (WHO)⁷ in favor of combined treatment of chemically dependent people:

"While recognizing that there are important differences between types of drug dependence, the Committee recommends that problems of dependence on alcohol and dependence on other drugs should be considered together, because of similarities of causation, interchangeability of agent in respect of maintenance of dependence and hence, similarities in measures required for prevention and treatment" (p. 41).

Spanning 10 years, Carroll and Malloy,⁸ in their review of the literature dealing with treatment programs, concluded similarly to WHO, that the literature reflected increasing evidence pointing to multiple substance abuse, thus pointing the way to combined

Table 1
Comparison of Alcoholics and Drug Abusers on Marital Status

	Single	Married	Other	Total
Alcohol	113	295	211	629
Drug	31	14	12	57
Total	144	309	233	686

$X^2 = 41.66, p. < .01$

Table 2
Comparison of Alcoholics and Drug Abusers on Age at Admission

	Alcoholics (N = 634)	Drug Abusers (N = 57)
Mean Age	39.47	26.11
	$F = 35.17^*$	

$p. < .01$

programming.

In 1972 we began to see evidence of codifying data relating to the issue of combined treatment. Brien, Kleiman, and Eisenman⁹ administered the 16 PF to 25 alcohol users, 25 heroin users, 25 methedrine users, and 25 mixed drug dependents, to examine personality characteristics and compare their findings. Differences for all groups were not greater than one standard deviation away from the adult norms. The major exception was that all groups but the alcoholics had below average ego strength. They concluded that few differences exist between alcoholics and drug abusers which would seem to support combined programming.

In another study, the type of chemical used seemed to make relatively little difference in measured personality characteristics on the 16 PF. There were trends in the data suggesting that heroin and polydrug users were more

happy-go-lucky, while alcoholics were somewhat more depressed. The authors found many more significant differences by age than by sex or drug.¹⁰

In summary, the literature seems to indicate many more similarities among chemically dependent people than differences. Additionally, the literature seemed to support Ottenberg and Rosen's¹¹ suggestion that combined treatment programs should offer a variety of different treatment modalities to deal with differences when they occur.

Methodology

Subjects. All 691 subjects had been treated at the A-Center of Racine, Wisconsin which is a nonprofit, specialized hospital for the treatment of chemically dependent people.¹² In all cases, a primary diagnosis of either alcohol (634) or drug abuse (57) was determined. There were 558 males and 133 females. Race categories were:

Black—87, White—566, and other—33 (5 subjects had missing ethnic data but were included in this study). Three hundred and nine participants were married, 144 single, and 233 were other.

Instrument. The 16 PF was administered to the subjects as a measure of their personality characteristics to determine similarities and differences according to age, primary diagnosis, and marital status. The instrument consists of 187 items and 16 aspects of personality, *e.g.*, reserved vs outgoing, are purported to be measured. Standard scores on the factors range from 1 to 10 with a score of 5 or 6 considered statistically average.

Procedure. Records of those people who participated in this study were retrieved from the A-Center and analysis of variance (ANOVA), t-test, and Chi square were performed, as appropriate.

Results

Drug vs Alcohol. A statistically significant difference was found between the two diagnostic groups on the variable of marital status (Table 1). Married alcoholics comprised 47 percent of their diagnostic category. In contrast, only 26 percent of the drug group was married while 54 percent was single. On the variable of age at time of admission, the drug abusers were found to be significantly younger ($X = 26.11$) than the alcoholics ($X = 39.74$), (Table 2).

To examine possible personality similarities and differences, a comparison of persons in these diagnostic categories was made using the subjects' test scores on the 16 PF (Table 3). Significant differences obtained between the 2 groups were found in 7 of the 20 comparisons. For example, for Factor A, reserved vs outgoing, drug abusers were significantly more reserved (4.35) than alcoholics (5.21). There were no statistically significant differences between diagnostic categories on 13 fac-

tors, *e.g.*, both diagnostic categories rated themselves as more shy than the normative population (factor H). It should be noted that nonsignificant difference comprised over half of the possible factors, thus, many similarities between the diagnostic groups were clearly evident.

Age. The factor of age was examined statistically using analysis of variance (ANOVA) and Chi square. Diagnostic categories and marital status for the age categories are presented in Table 4.

A comparison of persons in the preceding age categories was made using the subjects' test scores on the 16 PF (Table 5). Significant differences were found for 9 of the 20 scales.

There were no significant differences between age categories on the 11 factors. It should be noted that these factors comprised over half of the possible factors thus, many similarities between age categories were clearly evident.

Discussion. Both similarities and differences existed between alcoholics and drug abusers. Yet, the examination of the results yielded more similarities than differences. This finding refutes Lief and Pittman's emphasis on differences among chemically dependent persons and their recommendation for separate treatment programs.

Specifically, it was found that on the 16 PF, 13 similarities in personality factors existed between alcoholics and

Table 3
Comparison of 16 PF Scores of Alcohol Abusers and Drug Abusers

Factors	Alcohol (N = 634)	Drug (N = 57)	F-Ratio
A	5.21	4.35	8.00 **
B	5.48	6.16	3.50
C	3.70	3.39	1.73
E	5.24	5.83	2.13
F	4.98	5.60	1.72
G	5.42	3.90	25.84 **
H	4.42	4.16	1.42
I	5.93	6.46	1.60
L	6.64	7.04	1.50
M	4.91	5.05	.67
N	5.10	5.68	.67
O	7.29	7.53	.60
Q _I	5.63	6.58	8.03 **
Q _{II}	6.07	6.75	5.16 *
Q _{III}	5.17	4.39	7.23 **
Q _{IV}	7.31	7.88	4.56 *
Q _I	4.75	4.64	1.33
Q _{II}	7.46	7.84	2.35
Q _{III}	4.97	5.80	1.23
Q _{IV}	4.87	5.74	9.31 **

* $p < .05$

** $p < .01$

drug abusers. As major emphasis in most treatment programs (combined or separate) is focused on client self-

exploration, separate expertise in the psychological area by treatment personnel would appear to be superfluous. In-

tensive group work and personal counseling comprise important components of treatment for both alcoholics and drug abusers. Once the client begins to understand himself, he and the counselor can begin to explore alternative methods of behavior that can cope with the situations in life that lead to alcohol or polydrug dependence.

Drug abusers and alcoholics were found to be similar in terms of intelligence and assertiveness and were more shy, tender-minded, introverted, and anxious than the 16 PF norm group. These similarities have numerous implications for treatment personnel. For example, treatment personnel must assist both alcoholics and drug abusers with self-confrontation, self-exploration, and self-observation. Education and training programs which help chemically addicted persons in these areas appear warranted. Training and education in assertiveness skills and relaxation techniques seem particularly appropriate. An additional modality recommended for use in self-observation is video-tape review. Each of these methods provide for enhanced self-awareness leading to freedom from addiction. The finding that alcoholics and drug abusers were similar in terms of intelligence factors adds support for treatment combination relating to education and skill training.

Other implications include attitude changes for personnel who adhere to a separatism model and the need for a generic model for the training of treatment staff. The generic approach has been supported by many authorities in the field of chemical addiction. For example, Ottenberg¹³ stated that a generic perspective stresses the understanding of cultural and social determinants of numerous forms of substance abuse and the relationship of these problems to other social issues such as crime, poverty, and oppression. A major advantage that generic approaches provide is

Table 4
Age and Marital Status

Categories	18-19	20-29	30-39	40+
	n%	n%	n%	n%
Alcohol	7.01	152.22	156.23	315.46
Drug	16.02	34.05	4.01	7.01
Single	27.04	68.01	21.03	36.05
Married	2.00	62.01	81.10	154.22
Other	1.00	56.08	60.09	118.17

* 5 data missing

Table 5
16 PF Scores According to Age Categories

Factors	40+ Mature	18-19 Teen	30-39 Thirty	20-29 Twenty	F-Ratio
A	5.45	4.83	5.15	4.16	.44
B	5.32	5.52	5.74	5.71	.43
C	4.01	3.87	3.67	3.08	2.08
E	4.93	6.22	5.55	5.54	3.82 **
F	4.62	6.39	5.20	5.41	8.06 **
G	5.86	4.13	5.33	4.44	2.65 *
H	4.60	5.35	4.60	3.77	4.71 **
I	6.03	5.74	5.76	6.07	.20
L	6.30	6.96	6.87	7.11	1.93
M	5.15	4.48	4.62	4.83	1.21
N	6.21	5.35	6.16	5.48	3.01 *
O	7.02	7.57	7.37	7.72	1.51
Q ₁	5.24	7.09	5.84	6.23	4.33 **
Q ₂	6.02	5.83	5.88	6.57	1.07
Q ₃	5.61	4.78	5.11	4.31	2.18
Q ₄	6.94	7.44	7.60	7.83	1.40
Q _I	4.66	5.69	4.99	4.54	5.67 **
Q _{II}	7.11	7.47	7.63	8.02	3.43 *
Q _{III}	4.67	6.14	5.16	5.45	2.14
Q _{IV}	4.74	5.59	4.96	5.19	2.87 *

*p < .05

**p < .01

the combining of all aspects of substance abuse problems and programs into a single model with interrelated parts.

To ensure effective combined treatment programing, reorientation of governmental agency policy makers is suggested. Based on the history of government involvement in chemical addiction services, a broad-based, educational program is required. With increased government emphasis on accountability in both service and fiscal areas, a valuable case for combined treatment (based on this study's results) can be proposed.

Additionally, personnel who possess a generic background would be more amenable to provide services in a combined treatment program. On the other hand, specialists with selected skills would be more limited. As funding sources for treatment programs decline, this proposal takes on added meaning.

Physical facilities which could accommodate both alcoholics and poly-drug abusers would be more economically feasible. Similarly, chemically addicted people serviced in a combined facility would be required to deal more with their behavior and personalities than the specific chemical that has been abused.

An examination of the significant differences yielded no clear pattern. Age, however, seemed to account for the greatest number of differences (9), which supported Kissin's¹⁴ suggestion of separateness based on demographic characteristics, not primary diagnosis. Age was demonstrated to be a factor in personality differences in Ciotola and Peterson's study¹⁵ and the results of the present study were in this same direction.

Although the number of drug abusers was considerably smaller than the number of alcoholics, the findings of this study indicated that combined treatment for chemical abusers has merit. Treat-

ment programs should be cognizant of the few differences found and account for these differences by offering varied techniques and modalities within the combined approach.¹⁶

Conclusion

Alcoholics and drug abusers were compared on the basis of age, marital status, and personality trait factors on the 16 PF. The majority of the comparisons yielded similarities among alcoholics and drug abusers but there were a few significant differences. Age seemed to account for the greatest number of differences (9). The younger group was more happy-go-lucky and energetic, therefore, treatment facilities may expect some acting out behavior from this group. If combined treatment facilities need to modify their approaches at all, modifications may have to be based on age.

Obviously many similarities exist between chemical abusers and where accommodations need to be made, the influence of age must be considered. It is not clear, from this study, in which direction age shows its effect. Additional research is required which would match diagnostic categories, drug vs alcohol, on the varying age categories and then compare them on personality factors.

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Staffing Food Service Operations

A. Philip Nelan, F.S.C., Ph. D.

During the last 5 years, the National Restaurant Association has conducted a Project With Industry (PWI) program to open to the foodservice industry the benefits of employing qualified people with impairments. The program is nationwide and involves state restaurant associations, their chapters, state vocational rehabilitation services, hundreds of facilities, and other organizations relating to people with disabilities.

Facilities have originated a variety of ways to prepare their people in the public eye for competitive employment in foodservices. Herein is a brief account of 10 models, including the operation of retail restaurants and bakeries. At least 16 additional units exist. All are staffed by people with mental, emotional, and/or physical disabling conditions.

The Models

The sheriff at Otoe County Jail happily finds one of his problems solved. The nutritionist says the menus yielding 1900 calories a day exceed expectations. And the prisoners aver, "It's a lot better than it used to be," and "The food is the best I had since I've been here." The trainees of

the *Region V Mental Retardation Service, Nebraska*, preparing and serving the meals for the jail grow confident about eventually securing a place in competitive employment.

The training program of Region V, Nebraska City, won the contract to feed the jail inmates, 7 days a week, early this year. The trainees have not only adjusted to a rigorous schedule morning, noon, and night to provide the meals, but they are also learning to buy supplies, to plan meals, to store and inventory their commissary as well as to prepare, package the meals in styrofoam containers, and to deliver them at the jail. Budgeting is not the least important item of concern to maintain the high level of satisfaction on a strict per diem; they also learn to attend to costs.

At *Sheppard Air Force Base*, Wichita Falls, Texas, about 12,000 airmen, airwomen, and pilots in technical training are served in six very modern, cafeteria-style dining halls by people with disabilities.

The Individual Development Center, Inc., at Wichita Falls, has had the foodservice contract with the base the last 2 years and conducts all operations in foodservices on the base.

Currently 175 people with handicapping conditions do 75 percent of the hourly work in the preparation and serving of meals, and in the maintenance of the commissary operations. Through three classifications of jobs in nonskilled, semiskilled, and skilled categories, the trainees advance in career opportunities according to their abilities. Some have trained and become meat-cutters at the refrigerated plant, others have learned baking and pastry preparation, and a few are second cooks.

The Donut Shop, under the auspices of the Hallelujah Corporation, La Mesa, California, conducts a well organized apprenticeship training and applied skills program for the developmentally disabled. Procedures aim at "normalization" and require the trainee to exercise notable initiative in moving between instruction and work-site phases of the program.

As an apprentice, the trainee learns by applying the explained and demonstrated skills on the job in regard to safety and health, food preparation, machine operations, inventory keeping, shipping, sales, table service, packaging, and money handling—the many facets of an actual retail business at the Donut Shop.

Under the professional guidance of a baker/teacher, trainees also participate in all aspects of doughnut making, and take responsibilities for sales, displays, customer service, and general food handling. These experiences afford the trainee opportunities to display sufficient background knowledge and abilities to be declared qualified as job-ready and to go into competitive employment.

At Libertyville, Illinois, *The Country Inn* gives retarded residents at the Lambs firsthand experiences in conducting and staffing an up-to-date sit-down restaurant which has drawn the patronage of local businessmen

for meals, especially lunch. The accommodations serve conferences, parties, and a growing clientele. The executive chefs of Chicago have for years overseen the development of foodservices at the Lambs.

This residential facility conducts a pet shop, and a gift shop, as well as a bakery on the property. The young trainees learn to work according to their interests and abilities. They are enabled to meet and deal with the public. *The Country Bakery* has grown popular in the area, and is reputed for its cheese bread, nut bread, turnovers, cookies, and doughnuts.

The Mint, a unique commercial restaurant in Seattle, Washington, recently opened and employs four mentally retarded persons in key positions. Three, one severely retarded, wait on tables, and the fourth is a dish washer. All are graduates of the Food Service Vocational Training Program of the Child Development and Mental Retardation Center at the University of Seattle. The restaurant offers full service: breakfast, lunch, and dinner in the market area of the city.

The Country Squire Restaurant, Killingworth, Connecticut, colonial in every aspect of its structure which was built in 1794, seats 83 patrons and is staffed by handicapped people under continuing training. The Shoreline Association for Retarded and Handicapped Citizens (SARAH) sponsors the Squire and the smaller, colonial *Apple Doll House Tea Room* in nearby Guilford.

Through graded steps in a well organized curriculum, people with a range of retardation learn to work in public as they serve transient as well as local clientele in real restaurant settings. The final goal of training being entrance into competitive employment, their supervised training aims to give them opportunities to acquire

skills in various kitchen roles beyond dish washing, and become cook's and baker's aides in preparation of vegetables, salads, pastries, breads, muffins, as well as the technique of being a food checker, storeroom supervisor, etc. Mastering one skill qualifies each to undertake training in another and finally to be introduced to meeting and serving the public as waiter/waitress, bussing person, host or hostess, and cashier.

The restaurants profit by the horticultural program, also sponsored by SARAH. The plants and flowers in the restaurants' settings and the flower gardens, the well-kept grounds, are the landscaping services of trainees in SARAH's other specialty, horticulture.

Local restaurants at Owensboro, Kentucky, have absorbed 22 mentally-handicapped persons, all experienced through *Pinocchio's*, a shoot of the *Opportunity Center* and an enterprise of the Owensboro Council for Retarded Citizens.

Defying negative views about the capacities of mentally retarded, the Owensboro Council decided to adopt a sophisticated training program for qualifying persons from the Center 3 years ago and opened *Pinocchio's Dell* in the center of town. A profitable business, no longer looking for grants, now serves 200 to 300 patrons a day and trains about 50 people in a year. Trainees have found employment at the local Morrison's, Wendy's, Twigg's, and McDonald's.

Pinocchio's Dell has drawn national attention and is influentially spawning like efforts as far away as Florida, Ohio, and Pennsylvania. At home the community's supporting acceptance of the restaurant has moved the Council for Retarded Citizens to add *Pinocchio's Bakery and Sandwich Shop* in the opposite part of

town. The project trains groups of selected people with disabilities as bakers, baker's helpers, bakery workers, and bakery cleaners in the daily production of doughnuts, pastries, pies, and cakes.

The Kaynor Regional Vocational School at Waterbury, Connecticut, has a joint program with the *Waterbury Easter Seal Food Service Program*. Trainees provide meals for a limited number of inhouse staff and companions four evenings a week. The trainees follow a graded curriculum directly related to cooking: it teaches them from the rudiments "to whip up soups, meat courses, vegetables, and tasty breads and desserts." As part of their schedules, trainees gain onsite experiences one day a week at one or other foodservices, such as Holiday Inn, Harbor Mist, or the hospital among other local restaurants.

Three agencies in the mental health field conduct distinctive programs through food services as transitional training opportunities for recovering persons to find their ways socially, economically through work adjustment to independent living.

Pie-in-the-Sky Pastry Shop, Albany, N.Y., is a neighborhood retail bakeshop featuring a variety of handmade goods and pastries ranging from breads and rolls to cookies, cakes, and pies. The uniqueness of the bakeshop is not just its baked-fresh-daily products; it is also a vocational training site.

Employees have been through emotional problems and at different stages of ability to function vocationally under pressure. Twenty-two to twenty-five people, according to aptitudes and interests, are matched to job slots in the total operation of the bakeshop: mixer (weighing, measuring, operating equipment), bench hand (cutting, shaping, pressing dough), pick



(Front Cover and above) Scenes are from Pinocchio's Dell operation in Owensboro, Kentucky, which has drawn national attention.



Prisoners at the Otoe County Jail in Nebraska City have at least one thing to cheer about—good food—catered by the Region V Mental Retardation Service.

up and finish (finishing and allocating of baked goods for display and sales), cleanup (maintenance), cashiers, and sales persons.

The structured work activities provide the employees with a sense of community and social status, meaningful work which pays them in accordance with the minimum wage scale, and real on-the-job training in all features of baking under an executive chef and, finally, preparation for competitive employment and independent living.

The opening of the *Cafe* adjacently will add slots for training in serving, bussing, chef's assistants, maintenance, etc.

This vocational training site is sponsored by the Rehabilitation Support Services Inc. of Albany and in part funded through the Community Support Service of the Office of Mental Health. Many of the persons in training, perhaps for the first time, receive competitive wages; all come to know customer satisfaction with their freshly baked products.

At the *Bohemian Cafe*, St. Petersburg, Florida, recently opened, nine persons from the Boley Manor center, staff the operation as cooks, waitresses, cashiers, busboys, and dishwashers to gain food experience in the working world.

The note of informality dominates the well-run service: soups and sandwiches may have humorous beat-generation names but the clientele is increasing and the management is looking to moving from just a lunch-time business to breakfast service and eventually into evenings.

The object of the manager and trainers of these emotionally improving people is not only to aid them to strengthen and stabilize through work-therapy but also to open to them the possibilities of discovering a place in permanent employment and

independent living when they are ready.

The *Eden Express Restaurant* at Hayward, California, also serving people recovering from bouts with emotional pressures, takes 21 trainees through all phases of restaurant operations from the back to the front-of-the-house service techniques in a 5 months course. Since its opening in 1978, the project has drawn financial support from corporate industry and has placed its people with Denny's, Montgomery Ward, McDonald's, and The Ranch, among other operators in the area.

Not alone has the quality of breakfasts and lunches attracted a clientele that keeps the operation in the black. But the promotion of a novel idea, "Chef of the Day," cultivates public and corporate attention: prominent community members, such as the Mayor and judges, vaunting culinary skills, prepare their favorite dish as a special of the day and invite friends to eat and watch them cook.

The *SMART* program at Beach Haven Crest, N.J., and the Contract Work Station at the Nebraska Methodist Hospital, Omaha, and at the Marriott Hotel, Southfield, Michigan, offer variants in training at the work place.

The owner and operator of the *Chain Lane Restaurant* in the New Jersey resort area turned his kitchen and dining hall into a school during the off-season, fall and winter of the last 2 years, to train 12 to 15 ex-addicts at a time from Discovery House, a rehabilitation center. *SMART* (Sites Made Available for Restaurant Training) is a 3 months, full-time program to introduce rehabilitated people to all aspects of kitchen operations and the preparation of food in a restaurant.

In 2 years, more than 40 young men and women completed the rigor-

ous course and found employment in the industry. Sophistication and challenge motivate the students from the first day when they don aprons and hats and learn the rudiments about kitchen equipment, safety, and maintenance. Top level chefs from the casinos come in turn through the 3 month period to teach the preparation of soup stocks and basic sauces, elaborate dishes, decorative pastry items, and salads as well as specialty foods. Too, the trainees see the fruit of their work as they prepare food for senior citizens and serve lunches 2 days a week to retarded citizens, or when called upon to cooperate in a civic event by preparing soups or snacks.

The arrangement of Contract Work Stations is exemplified at the Nebraska Methodist Hospital in Omaha, and at the Marriott Hotel, Southfield, Michigan. The hospital and hotel set aside a specified unit of work in foodservices to be performed under contract respectively with Eastern Nebraska Community Office of Retardation, Omaha, and New Horizons, Southfield. A work force of job-ready persons with impairments from the agency under a supervisor-trainer, responsible for production and quality control, does the required day's work in a designated unit of the foodservices, such as tending and supplying the salad line, preparing food items, cleaning, operating the dishwasher and other equipment, maintenance, etc. The agency keeps all records about the individual, and has the responsibility of paying their salaries. The ultimate goal of the plan is eventually to prepare and advance these people into permanent, competitive, unsupervised employment.

General Conclusion

These programs are community based. Their visibility opens the eyes of the public to realize that people

with disabilities have distinctive abilities, too. Most important, actually working in the public eye, the trainees experience the discipline of work and learn what being socially acceptable means. In the setting of these restaurants and bakeries, the trainees work in teams and adjust to do varieties of jobs before the business-hour: maintenance and cleaning, setting tables, readying linens.

Successful programs require a carefully worked out curriculum: specific skills are broken into small components and taught one step at a time repetitively; steps are taken to build social awareness for pleasantly serving customers as helpful waiters or waitresses without being overly or underly solicitous. Finishing their period of experiential training, these people with impairments readily move into the world of competitive employment.

These are "all-win" programs and deserve much support to see them through to stability and success, particularly in our time of recession. Local membership of the restaurant associations have given some a helping hand as advisors to management. The agencies, managers, and counselors promoting these operations are confirmed in their belief in their clients. The public gradually learns to accept, encourage, and applaud the successes of people struggling with handicapping conditions. The impaired people, already recognizing that they are total persons and have capacities, also enjoy a reenforcing illumination about themselves: They have a new awareness, namely, that the public is gradually accepting them.

Brother Nelan is a Christian Brother and Director of Handicapped Employment Programs, National Restaurant Association, Washington, D.C.

References

- The Otoe County Jail*
Vocational Service Center
Region V Nebraska City
808 8th Corso, Box 614
Nebraska City, Nebraska 68410
402-373-3306
- Sheppard Air Force Base*
Individual Development Center
Inc.
3401 Armory Road
Wichita Falls, Texas 76302
817-766-3207
- The Donut Shop*
Hallelujah Corporation
8808 La Mesa Blvd.
La Mesa, California 92041
714-464-3882
- The Country Inn*
- The Country Bakery*
The Lambs Inc.
P.O.Box 520
Libertyville, Ill. 60048
312-362-4636
- The Mint Restaurant*
90 Pike Street
Seattle, Washington
206-624-1365
- The Country Squire Restaurant*
Route 80
Killingworth, Conn. 06417
203-663-2820
- The Apple Doll House Tea Room*
55 Park Street
Guilford, Connecticut 06439
203-453-2933
- Pinocchio's Dell*
217 West Second Street
Owensboro, Kentucky 42301
502-684-3220
- Pinocchio's Bakery and Sandwich Shop*
9th and Center Streets
- Owensboro, Kentucky 42301
502-683-7377
- Waterbury Easter Seal Food Service Program*
118 Echo Lake Road
Watertown, Conn. 06795
203-274-6733
- Pie-in-the-Sky Pastry Shop*
383 1/2 Madison Avenue
Albany, N.Y. 12208
518-463-7355
- The Bohemian Cafe*
1034 Fourth St., North
St. Petersburg, Fla. 33701
813-821-0425
- The Eden Express Restaurant*
779 B Street
Hayward, Calif. 94591
415-886-8765
- The Smart Program*
Chain Lane Restaurants
34 W. New York Avenue
Beach Haven Crest, N.J.
609-492-4602
- Nebraska Methodist Hospital-Omaha*
Nebraska Network of Training Services
University of Nebraska
444 South 4th Street
Omaha, Nebraska 68131
402-559-5327
- Marriott Hotel-Southfield, Mich.*
New Horizons
117 Turk Street
Pontiac, Michigan 48053
313-338-6176
- OTHER SIMILAR PROGRAMS**
- The Eating Place*
Monodock Workshop
76 Main Street
Peterborough, N.H. 03458
603-924-6359
- Favarh*
Box D
Avon, Connecticut 06001
203-678-0313
- The Coffee Shop*
Goodwill Industries
5200 Jensen Drive
Houston, Texas 77028
713-692-6221
- Country Oven (Bakery)*
Appalachian Center
Oakland, Maryland 21550
301-334-8146
- Commercial Baking and Industrial Trade Training Program*
Goodwill Industries
1634 West Michigan Street
Indianapolis, Indiana 46222
317-636-2541
- Riverside Industries*
One Cottage Street
East Hampton, Mass. 01027
- Polaris Restaurant*
Polaris Vocational School
7285 Old Oak Blvd.
Middleburg, OH 44130
216-243-8600
- Industrial Kitchen*
North Rhode Island Chapter (ARC)
80 Fabien Street
Woonsocket, R. I. 02895
401-769-9720
- The Taste Bud*
(School for Work Experience)
19600 Cass Avenue
Mt. Clemens, Mich.
313-286-0230
- The Spice Rack*
205 Madison Avenue
Elmira, N.Y. 14902
607-734-6151

COMMENTARY

... On PWI article

... We appreciate your placing our paper on Projects With Industry at the top and have already received many comments on it. ("Projects With Industry: The Concept And The Realization" Irwin Kaplan and Norman Hammond, Nov-Dec 1982, p. 3)

... An omission at the top of the third column of page 3 of the magazine left even me wondering what it was I had said.

Delete the 1st line of the 1st paragraph in column 3 of page 3 and replace it with: "Projects with Industry have proven successful because, among other things, placing disabled people in ...

Of more significance, at least to the people involved, was the casual captioning of the excellent photos. These pictures were taken at the Computer Programmer Training Project of the Human Resources Center in Albertson, New York. This is not itself a Project With Industry since it is funded by the State of New York; it was, however, initiated by us under the sponsorship of our PWI. The Human Resources Center, which as you know is internationally known, does include as one of its elements a manufacturing facility organized as Abilities, Inc. It would have preferred, I'm sure, to have been referred to by its proper and more widely known name. Mike Kaskel, the center's data processing instructor, has done an outstanding job. He was pictured twice; I'm sorry his name wasn't mentioned.

The original draft would have avoided some of this awkwardness since it included a listing of the 20 training locations and would therefore have provided the proper name for

this center. It's omission and the inclusion of these pictures made some internal reference to the Human Resources Center mandatory. I'm sorry that we failed to recognize this. **Norman C. Hammond**, International Business Machines Corporation.

... On Accessibility

I just finished reading the Nov/Dec '82 issue of *American Rehabilitation* and I am writing about the article on the Smithsonian— "View From The Castle". Although it is a good article—there are a few things that stand out—Mainly, it is obvious that, with the exception of the Air & Space Museum, Mr. Brubeck did not visit the various Smithsonian buildings to gather his information, but relied on the literature put out by the Smithsonian. Otherwise he would have known that the Renwick Gallery not only has a ramp, but has had one for a couple of years—my first visit to D.C. was in Sept. '81 & they had a ramp then—the ramp is down to the service entrance on 17th Street—it is a bit steep, and coming up it can be difficult, but it is there. Also to enter the National Portrait Gallery & the National Gallery of American Art one must enter through the garage—there is no other ramp available.

Although Mr. Brubeck's article does present a very good picture of the accommodations that the Smithsonian has made for the handicapped (especially those in wheelchairs), had he visited the museums personally, he would have discovered that there are still many problems. My most recent visit to D.C. was in Oct. 82—and I doubt there have been many changes since then. What Mr. Brubeck said about the Freer was correct, but he neglected to mention that the gift shop in the Freer is completely inaccessible—even with help. Also

most of the exhibits in the display cases are visible, but the labels are not—as they are flat in front of the object, they are almost impossible to read.

As for the other museums, the Museum of American History (my favorite) has two of its major permanent exhibits on ramps—with rugs—making it extremely difficult for persons in wheelchairs to view these exhibits—especially persons with decreased upper arm strength who use manual wheelchairs. I have very good upper arm strength and have difficulty maneuvering on the ramps. Of course, I would like to see all rugs in the museum removed—it would make all the museums so much more enjoyable to visit. Also the train exhibit at the MAH is inaccessible—there are stairs at both ends of the hall.

As for the Museum of Man/Museum of Natural History many of the exhibits are placed high in display cases—I'm thinking, in particular, of the Hall of Gems. And again there is the problem of exhibits on ramps.

And any discussion of the accessibility of the Smithsonian should also take into account the Mall—although, the Smithsonian is not responsible for it—it is nearly impossible for someone to push themselves across the gravel walkways.

Considering the size, and the age, of the buildings I think the Smithsonian has done a very good job in making the various museums accessible to all. But I really think that you should require that the author of an article on accessibility of buildings, programs, etc. should visit them first, and not rely on literature that is outdated, or that only gives the positive side of accessibility. I also feel that the article should have included some of the

(Continued on page 29.)

Life Enhancement At Vinland National Center

Joyce A. Weil

It was fun to laugh and joke with the others that evening as we ridiculed the pinch pots, howling at the ugly, grotesque shapes. I looked at my product and thought, "It's a dumb little pitcher, but I made it myself." Most of us were amateurs, beginners in pottery-making. To see and



feel the moist, brown clay was a new experience; learning to form a pot from a glob of the gooey stuff developed a new skill. The culmination of

our activity was a group sculpture as a commemorative gift to the Vinland National Center from Session 3.82.

Who were we? We were the participants and evening staff at the Life Enhancement program during a three-week healthsports session at Vinland National Center. Three of the people there were able-bodied; the rest were physically handicapped in some way—strokes, spinal cord injury, brain damage, hearing impairment, multiple sclerosis, and blindness. We were a young group, from early 20s to mid-30s. One of the women participants was missing that evening—her multiple sclerosis begged for rest after a day of swimming and active exercise.

Donna, a blind musician and songwriter from Philadelphia, had come to Vinland to become more proficient at cross-country skiing. Her guide dog Simba, a large black Labrador retriever, rested patiently under the table as she pinched and molded a mug.

Ken, who is deaf, is an active sportsman, especially skilled in kayaking. He meticulously crafted a kayak, an igloo, and the sign language, "I Love You," out of the clay. He also had a dog, Laska, a husky who was waiting outdoors in the cold winter darkness. Laska was used for pulling sleds through ice and snow.

Bill, brain-injured in an automobile accident, had come to Vinland from New Jersey to learn new ways to join the mainstream of activity outside his home. He had difficulty with his manual dexterity, but he was so willing to try fashioning a pinch pot out of the clay, and so pleased to be with the group, that we gladly helped him.

Jan, able-bodied, was the chief recreation therapist at a rehabilitation hospital in Boston. She was thoroughly enjoying the change from a structured hospital setting to a flexi-

ble, healthful, outdoor atmosphere. She made gifts from the clay—a handprint wall hanging and a clown for her niece. Her gift to the hospital would be the knowledge of healthsports and wellness she had gained at Vinland.

Brian, paraplegic, had been hit by a car as he rode his bicycle to college. He was enjoying the group activity but not feeling too inspired by pottery-making. His interest lay more in sports—weight training, sled skiing, and wheelchair racing. Watching Brian go down stairs in his chair was inspiring, and breathtaking.

Jon was part of the evening staff, a student from Moorhead State College completing a recreation therapy degree. He had a common bond with Brian; he also was hit by a car while riding his bicycle. However, instead of a spinal cord injury, he had sustained a head injury that caused some left side weakness, a slow gait, speech and balance problems. His attitude toward life was humorous and philosophical. That evening, as we punched and mangled the clay into misshapen forms, he asked, "What is normal?"

A 32-year-old woman had found herself at home watching too much TV two years after a stroke had paralyzed her left side. When she heard about Vinland she decided the program had been invented for her and would be a good learning experience. She especially appreciated horseback riding, as she had owned and trained horses.

The purpose of Vinland is to provide healthsports and lifestyle training for persons with varying abilities and for professionals who work with them. Life Enhancement is one of the three major components of the Vinland programs. The other two are Healthsports and Health Promo-

tion/Education. Healthsports are lifetime, noncompetitive activities that foster higher levels of mental, physical, and emotional well-being and use the outdoor environment whenever possible. Some healthsports this group had experienced were swimming, weight lifting, aerobic dance, horseback riding, kayaking, and tandem biking. Health Promotion/Education addresses topics such as medical self-care skills, prevention and care of injuries, and nutrition. Life Enhancement augments each participant's individual program.

A morning Life Enhancement topic might be assertiveness, with role play demonstrating effective ways to ask for help or inclusion in an activity. Also discussed and practiced are relaxation techniques such as yoga. Sexuality and disability is another important topic.

Leisure time has increased for most Americans, but often people with different abilities, who may not work full time, have more unscheduled hours each day. In a variety of evening and weekend Life Enhancement programs, alternatives for creative and constructive leisure and recreational activity are presented. These include, but are not limited to, music, square dance, museum and theater attendance, jewelry-making, and pottery. After the Vinland experience, it is hoped that ex-participants will have the interest and motivation to find and take advantage of their home community leisure resources that they discover are meaningful for them.

Ms. Andrews is a free-lance writer and has taught classes for mentally retarded young adults. Presently she serves as Administrative Assistant, National Outreach, Vinland National Center, Minnesota.

REPORT RESOURCES

WHEELCHAIR MOBILITY. (Grant #G0082000025/NIHR). Final Report of the Rehabilitation Engineering Center at the University of Virginia, Charlottesville. One of the core areas of research at the University of Virginia Rehabilitation Engineering Center has been wheelchair mobility. The prime objective has been to develop information useful to users, manufacturers and designers.

The bulk of the report consists of a presentation of the basic information, which although incomplete, points the way to improved design. The remainder of the report describes some of the experimental designs for wheelchairs and components, presents the results of some evaluations conducted, and lists the characteristics of some 200 users in Charlottesville and environs. A brief description of the test equipment, and a listing of U.S. patents concludes the report.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

A CREATIVE PARTNERSHIP: PROJECT WITH INDUSTRY. (Grant #G008005826/NIHR). Electronic Industries Foundation—A Resource Manual for the Development of an Industry Initiated Project to Facilitate the Employment of Disabled Persons Nationwide.

This resource manual is intended for use by organizations contemplating or planning the development of an industry oriented outreach program for the employment of disabled individuals. It will be of particular interest to national organizations—trade

associations, industry groups, alliances of manufacturers and the like—which may benefit from the planning, demonstration, and experience of another national organization.

For those wishing to undertake similar projects, this manual offers a "how to" approach which covers such areas and topics as: management systems and controls, evaluation and accountability, planning, marketing, and training.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

THE UNIVERSITY OF TENNESSEE REHABILITATION ENGINEERING PROGRAM, FINAL REPORT OF ACTIVITIES. (Grant #G008002933/NIHR). Memphis, Tennessee

The core area was to develop concepts and assistive devices to enhance the life potential of young individuals with severe neuro-motor involvement, with emphasis on specialized seating, mobility, and ADL needs.

The report has sections on the background and orientation of the program, including a summary of major accomplishments; research and development; evaluation and research utilization; and, client services.

For copies contact: Susan McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

National Institute of Handicapped Research

This article is based upon Dr. Reswick's testimony presented before the Senate committee on Labor and Human Resources and the House Subcommittee on Science, Research and Technology on September 29, 1982. One of the very few persons elected to both the National Academy of Engineering and the Institute of Medicine of the National Academy of Sci-

performance, safety, and failure modes of a device. It is concerned with the quality of the engineering design and the potential for maintaining the highest standards of quality control in production and subsequent maintenance.

2. *Internal Clinical Evaluation:* At the inception of a new design/development project, it is virtually im-

working on various improved versions, but at some point, a manufacturer must reach a decision that a product or a device has attained a level of development sufficient to warrant production and distribution for profit. It is absolutely vital that this occur if the firm or agency is to be able to encourage a continuing R&D effort in the first place.

A Plan For Handicapped Technology Evaluation

James B. Reswick, Sc.D.

ence, Dr. Reswick was asked to present his expert opinion on the problem of evaluating technological devices and to respond to other points raised in the Office of Technology Assessment's report *Technology and Handicapped People*. Dr. Reswick believes that achieving proper, thorough, and accurate evaluation of technological devices for handicapped people is one of the greatest problems faced in rehabilitation engineering today. In this article, he proposes the establishment by the Veterans Administration and the National Institute of Handicapped Research of a National Rehabilitation Technology Evaluation Program.

Evaluation in the field of Technology for the Handicapped is simply the determination of the degree to which a device meets the needs of a handicapped person. Three distinct types of levels of evaluation should be considered:

1. *Technical Evaluation:* Technical Evaluation requires scientific testing and/or expert analysis of the mechanical, electrical, materials, etc., factors that relate to technical

possible for any open person clearly to state specifications of a device to meet a patient's need. An initial attempt can be made by an effective team that includes medical, engineering, allied health, and technical professionals. Such a medical engineering team can set down initial performance goals and proceed from these goals to define research and development tasks. Still, the inescapable fact remains that *it is not until the device is first tried in the clinic on a patient that many problems not recognized in the beginning become clear and the possibility of stating nearly complete design specifications becomes real*. This process—*Internal Clinical Evaluation*—is vitally necessary, but often lacking.

Inevitably, the first prototype must be redesigned and redeveloped, and it is seldom that only one cycle of this process is required. Rather, the process becomes a continuous one, with new and improved models being worked on and evaluated. Often it is difficult for a developer to accept that his designs must be frozen for production at a time when he is still

3. *External Clinical Evaluation.* The third evaluation phase—*External Clinical Evaluation*—now becomes critical. In the United States, most new devices will come under the cognizance of the Food and Drug Administration (FDA). Classification levels require different degrees of clinical effectiveness and safety data but all require some reliable testing and evaluation process. Meeting requirements can be expensive and time consuming. But beyond just satisfying a federal agency, evaluation is important to the manufacturer's market success.

The market for devices for handicapped people defies quick, easy analysis. A device must fit a person's lifestyle and be more cost-effective than any other solution to be accepted by him and be authorized for payment by a third party. Each person is different and his personal needs are different. The challenge to a new device is to meet enough needs of enough persons to permit quantity production and distribution. Many highly motivated inventors create solutions for handicapped persons with whom they are personally involved, only to dis-

cover that no broad market potential exists for their device. Evaluation—in the clinic or in the community—is the only way to obtain a meaningful measure of the likelihood of success of a device and the feedback necessary to initiate changes that might lead to more general acceptance.

A manufacturer of devices for disabled persons faces a significantly more costly design, development and marketing situation than do most deliverers of technological devices. However, costs themselves are not the major problem. It is the risk engendered by the inability clearly to define the market potential of a new device that is the major barrier to industrial commitment in this field. What can be done to reduce this risk?

The first and most often stated need is for government to “stimulate” industry by subsidizing early research and development and tooling costs through either direct grants or the purchase of first production units at prices that include these costs. In the United States, such programs have been carried on by the National Science Foundation (NSF) (direct grants) and the Veterans Administration (VA) (prototype purchase). The Department of Health and Human Services has launched an Omnibus Solicitation for the Small Business Innovative Research (SBIR) Program. Some applications in the area of technology for the handicapped may be funded. Other agencies, including the National Institute of Handicapped Research (NIHR), are seriously considering such assistance. However, while subsidy will encourage industry to undertake the development of some products they would not otherwise consider, I do not believe it overcomes the fundamental problem of market risk. If a device truly meets a need for enough handicapped persons, it will succeed and costs will be

Fenderson Becomes NIHR Director



Douglas A. Fenderson was sworn in January 21 by Secretary of Education T. H. Bell as Director of the National Institute of Handicapped Research (NIHR) following his nomination by President Reagan and confirmation by the U. S. Senate.

As Director of the Institute, Dr. Fenderson will oversee a current budget of \$30 million for the research, training, and development of technological devices and equipment to improve the lives of handicapped persons, especially the severely disabled.

For the past 10 years Dr. Fenderson has been serving as Director of the Office of Continuing Medical Education at the University of Minnesota's Medical School. At the same time he has been a professor at the university's School of Public Health, and, since 1977, a scientist at the school's Center for Health Services Research. Dr. Fenderson has also been Executive Secretary of the Clinical Fellows Program at the Bush Foundation, St. Paul, Minnesota; where his chief concern was setting

up a medical mid-career fellowship program of physicians in rural areas.

Before his tenure at the University of Minnesota, Dr. Fenderson was Director of Special Programs in 1972-73 at the National Institutes of Health's Bureau of Health Manpower Education. From 1969 to 1971 he served as a Branch Chief at the Center for Health Services Research.

Dr. Fenderson has had extensive experience in the field of rehabilitation, one of the primary concerns of the NIHR. He served as Education Director of the American Rehabilitation Foundation from 1966-1969; Chief of Rehabilitation Services for the Minnesota Division of Vocational Rehabilitation from 1958 to 1963; and Director of Vocational Services of Sister Kenny Institute in Minneapolis from 1955 to 1958.

Dr. Fenderson pursued his education at the University of Minnesota, where he received a bachelor of science degree in industrial education and mathematics in 1952, and master's and doctorate degrees in psychology in 1956 and 1966, respectively.

A member and consultant on some 50 committees and task forces related to rehabilitation and medical education, Dr. Fenderson has also held various positions with State and national rehabilitation associations. He has also published nearly 50 articles on the subject.

Dr. Fenderson, 53, is a native of Streeter, North Dakota. He is married to the former Joyce Hansen, and they have four children.

covered. If a market does not exist (or cannot be created), the product will fail. Effective evaluation is the only way to determine the reality of market prognosis—the truth of a new device's potential to benefit enough handicapped persons at a cost commensurate to the benefit, either the Veterans Administration or the NIHR, whichever is most appropriate and jointly funded by both.

Centers would serve the needs of the Veterans Administration, evaluate new devices developed in NIHR programs, and undertake evaluations for the private sector through contracts and fees. Issues with respect to apparent mixing of public and private funds can, I think, be solved through enlightened and open administrative practices. Also sensitive are issues of apparent restraint of trade should a product be found defective and such information be freely available. Again, I believe, these kinds of problems have been solved before and the rights of entrepreneurs can be fully protected through enlightened and open administrative practices. The needs of handicapped persons are those of the nation as a whole, both public and private and can be dealt with effectively only through joint public-private efforts.

This suggested approach, designed around the needs and capabilities of the Veterans Administration, the NIHR and other federal agencies, is intended to serve the civilian sector as well. Once the kernel of the system is planted, it will grow and be nourished, mainly by the private sector, with service to other civilian agencies when requested. I believe in the potential of the proposed plan to become a truly *National Rehabilitation Technology Evaluation System*.

Let us examine in more detail what evaluation really means.

Effective evaluation—both technical and clinical—is a highly scientific process. Technical evaluation often requires sophisticated test equipment with protocols designed by high level engineers. Modern materials, advanced electronics, and computer technology are increasingly employed in new devices for the handicapped. Considerable skill and knowledge are required to predict all failure modes and to set performance criteria that will result in a cost-effective device.

Clinical evaluation is equally demanding of scientific expertise; often it requires a combination of medical and technical experts. Usually, a number of centers are involved in evaluating a new device with patients/clients. This requires a protocol that can lead to statistically significant and scientifically objective results. Testing methods, data to be collected, criteria for selection of patients/clients, and the form of reports—methodology, data, results, discussion and conclusion—all must be planned and carried out by skilled and knowledgeable professionals of high ethical and scientific competence.

Evaluation is often expensive and time consuming. For results to be credible and useful, scientific planning and execution are required. Management of an evaluation program is challenging and requires dedicated, full-time staff. Poor evaluations are worse than none at all, as they may lead to devices that disappoint the user becoming established in a delivery system, they can waste large amounts of money, and can possibly be dangerous.

Presuming that the manufacturer is successful in producing a useful technical product for handicapped persons, he then faces some additional problems not usually encountered in the distribution of non-medical de-

vices. These devices normally are prescribed by a patient's physician or an allied health professional. This means that the prescriber must be educated and trained in the application and use of the devices. Such training and education are costly. Also, the prescriber must be completely sure of the performance of the device before he can fulfill the ultimate responsibility that professional ethics requires of him. Thus, device development must usually occur in the context of a respected teaching-clinical facility if reported clinical experience is to be considered reliable by the prospective, prescribing health service community.

Here again, evaluation plays the central role. Professional journals will only accept results that have been clinically validated. Information for education and training and that given to providers and consumers must be reliable and specific as to performance and the details of the particular handicap for which it is applicable.

Another problem facing the manufacturer is the fact that electromechanical devices inevitably require maintenance and repair. The manufacturer must often assume responsibility for this service, but the establishment and maintenance of such a service in a limited market may well be too costly to justify. Therefore, many small firms with limited marketing, distribution and service capability refrain from producing rehabilitation engineering devices even though many have the technical capability and interest to do so.

Evaluation is again important, for it is in the field trials that potential repair and replacement needs are discovered. Some devices require redesign while others, because of cost factors, are accepted and kept functional through maintenance and repair. A manufacturer must, then, plan

his overall system to prepare for these needs.

A NATIONAL REHABILITATION TECHNOLOGY EVALUATION SYSTEM

"A coherent, adequately funded, and well-focused program of evaluation is necessary at all levels of technology diffusion and adoption. *Such a program does not currently exist in the disability-related technology sector.*" (emphasis added) (Conclusion statement of Section 7 "Evaluation of Technologies," p. 83, OTA Report "Technology and Handicapped People," May 1982.)

I concur totally with this most important conclusion of the OTA study. But to create such a system is not easy. It is far more costly than usually estimated, and its need is not well understood. I believe that while operational costs will be high, effective evaluation is a valuable component of a product's final cost and most evaluations can and will be paid for by the private sector. The elements of a potential evaluation system are now in place. All that is needed is a clear concept and a good beginning.

I do not propose a great institute filled with people and laboratories, although some in-house testing capacity will be needed. Rather, I suggest that two or more relatively modest centers, each having coordinating functions with information storage and dissemination capability, are all that is required to make a beginning. Resources abound throughout the nation to carry out clinical and community evaluations. What is needed is *effective program management* to ensure that protocols are scientifically designed, that patient and/or client groups are accurately and uniformly specified and that data and reports are consistent and objective. The evaluation centers should be designed to in-

clude a number of information dissemination models (e.g., a direct "800" telephone, computer network, frequent evaluation bulletins, comprehensive reports, and other innovative uses of communications systems). They would then become places to which consumers, providers, authorizers, manufacturers, and government agencies at all levels could turn for immediate answers and continuing information updates.

Were such a system of centers to exist with a moderate, accumulated history, manufacturers would have access to data on the nature of unmet needs, a way to determine the true potential of a new device and a source of data to develop credible information for many purposes. These are valuable commodities and represent legitimate components of a product's final selling price. Thus, a national evaluation capability can and should become self-sustaining.

Recommendation For Action

I propose that a National Rehabilitation Technology Evaluation Program be established jointly by the Veterans Administration (VA) and the National Institute of Handicapped Research (NIHR).

The Veterans Administration is the largest centralized purchaser of technical aids for the handicapped. The VA system of hospitals and medical centers is ideal for extensive clinical evaluations. Its procurement system requires the effective evaluation of technological devices and systems purchased for veterans. Comprising a large and structured market component, it commands the attention of producers of technology for the handicapped. The VA, for many years, carried on an evaluation program primarily through its Veterans Administration Rehabilitation Engineering Center in New York City, an activity

that has recently been deemphasized.

The National Institute of Handicapped Research, which funds the largest R&D program on technology for the handicapped in the world, is mandated by its legislation (PL 95-602) to promote the effective delivery of that technology to handicapped persons. NIHR for many years has required evaluation activities in its Research Center Program and it announced and completed evaluation as an important priority area for funding in 1983.

The VA and the NIHR have collaborated for years in their respective R&D programs and they are formally linked through the legislatively mandated Interagency Committee on Handicapped Research and its Subcommittee on Rehabilitation Engineering.

It is specifically proposed that at least two National Rehabilitation Technology Evaluation Centers (one in the East and one in the West) to be administered by either the Veterans Administration of the NIHR, whichever is most appropriate and jointly funded by both.

Centers would serve the needs of the Veterans Administration, evaluate new devices developed in NIHR programs and undertake evaluations for the private sector through contracts and fees. Issues with respect to apparent mixing of public and private funds can, I think, be solved through enlightened and open administrative practices. Also sensitive are issues of apparent restraint of trade should a product be found defective and such information be freely available. Again, I believe, these kinds of problems have been solved before and the rights of entrepreneurs can be fully protected through enlightened and open administrative practices. The

(Continued on page 29.)

COMPANION PROGRAM: First Of Its Kind

Marcia J. Gayle

Clara is a 68-year old senior citizen who was recently discharged from the hospital after treatment for severe arthritis. Since her mobility had become very restricted, she was unable to continue many of her usual activities and she had to hire an attendant to help her with the most essential tasks of daily living. She had never before hired or supervised an employee so she now faced several problems that she was not prepared to deal with. The attendant she hired refused to do work that needed to be done and often complained of being overworked. Clara soon found that her personality and her lifestyle were incompatible with those of her attendant. In addition, she was faced with the problem of limited and diminishing funds with which to pay an attendant's wages.

Margie is a young developmentally disabled adult who encountered great difficulty finding full-time employment. Although she has some skills in the area of domestic work, her lack of job experience and her need for further on-the-job training puts her at a disadvantage when competing with

faster learning workers. Margie's rehabilitation counselor has found that it takes her a little extra time to complete tasks and that she needs special guidance and individualized instruction when beginning a new work routine. Margie's parents are eager for her to live more independently but they do not feel she is ready to live away from home without some supervision.

Clara and Margie are now participating in a new pilot project called the Companion Program. The purpose of the Companion Program is to train people with developmental disabilities to become companions to seniors so that both may work and live together in the community. The basis of the program is an exchange of services. The developmentally disabled companion provides 20 hours of service to the senior each week in exchange for room and board. Seniors who might not be able to afford assistance, receive the help they need and companions get work experience and the supervision they require to become more independent.

The training and placement components are unique aspects of this project. All participants—seniors and companions—are required to participate in 3 weeks of training when they enter the program. The goal of this training is to provide each participant with an opportunity to gain the knowledge, skills, and information needed to enter into a working partnership. These skills enable the partners to obtain the maximum benefit from the program by establishing a reciprocal partnership. The curriculum for the companions includes helping people get around domestic chores, personal care, recreation, and clerical skills; the seniors receive training in how to supervise and give job instruction; both groups are schooled in communications and

getting along with others.

Clara and Margie have just finished this training, and they are now ready to implement their partnership. It became evident that Margie would be a good companion to Clara when it was discovered that they had established good rapport during training. Not only did they like each other, but their abilities and needs were complementary and their interests were similar.

The Companion Program is community-based from the start by the Coastal District of the Department of Rehabilitation. The idea for the program was suggested by the mother of a developmentally disabled young man. She supported her son's desire to move out of the family home in order to live more independently but was cautious because his prior attempts to live alone had been failures. She realized that he had some skills that he could transfer into a companionship situation and that this might be an ideal stepping-stone towards complete independence.

Further research and planning input came from various community agencies including the Social Security Administration, Los Angeles County Department of Public Services, the Employment Development Center, the Area Office on Aging, LA County Department of Senior Citizens Affairs, Behavioral Health Services, Senior Centers in Culver City, Inglewood and Santa Monica, the Santa Monica Volunteer Bureau and Torrance Family YMCA.

The program is funded by the Los Angeles Coastal District of the California Department of Rehabilitation. The Companion Program is being administered by the Los Angeles Comprehensive Rehabilitation Center (CRC). Training assistance is being offered from the Office of the Los Angeles County Superintendent of

Schools. Currently, the Companion Program is operating in the area comprised of Carson, Culver City, El Segundo, Hawthorne, Hermosa Beach, Inglewood, Manhattan Beach, Redondo Beach, Santa Monica, Torrance and the southwest portion of the city of Los Angeles. For further information, call Wendy Wolfe, Companion Coordinator, at 674-7050, ext. 4117.

The Los Angeles Comprehensive Rehabilitation Center is a cooperative venture of Daniel Freeman Hospital Medical Center, the LA Coastal District of the California Department of Rehabilitation, and the Westside Community for Independent Living, Inc. Ms. Gayle is a Public Relations officer with the LA Comprehensive Rehabilitation Center.

TECHNOLOGY

(Continued from page 27.)

needs of handicapped persons are those of the nation as a whole, both public and private and can be dealt with effectively only through joint public-private efforts.

This suggested approach, designed around the needs and capabilities of the Veterans Administration, the NIH and other federal agencies, is intended to serve the civilian sector as well. Once the kernel of the system is planted, it will grow and be nourished, mainly by the private sector, with service to other civilian agencies when requested. I believe in the potential of the proposed plan to become a truly *National* Rehabilitation Technology Evaluation System exists.

REPORT RESOURCES

A PROPOSAL FOR TECHNOLOGY ASSESSMENT AND TRANSFER TO REHABILITATION, PROJECT IMPART. (Grant #G008003085/NIHR). Final Report of the Research Utilization Laboratory (RUL) at the Texas Rehabilitation Commission, Austin.

The IMPART project demonstrated a cost effective model for using technology to benefit severely handicapped persons. The Texas Rehabilitation Commission has incorporated IMPART into the program. It is hoped that rehabilitation service providers will glean from this project elements which will increase the use of technologies nationally.

The report provides lists of equipment manufacturers/distributors; organizations, facilities, and services; IMPART Problem Disability Index; IMPART Problem Area Index; IMPART Journal and Magazine Articles; Presentations, Meetings, and Seminars; and Information Packets.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

INFORMATION SERVICES ON TECHNICAL AIDS FOR PEOPLE WITH DISABILITIES: AN INTERNATIONAL PERSPECTIVE. Proceedings of an international conference, Bellagio, Italy, 1981. Published by James D. Wolfensohn, Inc. Available from Rehabilitation International, 432 Park Avenue South, New York, N.Y. 10016. \$20.

FAMILY SUPPORT SERVICES FOR PHYSICALLY AND MENTALLY HANDICAPPED PEOPLE IN THEIR OWN HOMES. Hampden Inskip. Bedford Square Press, Brookfield, VT 05036. \$3.70.

THE CREATIVE PARTNERSHIP: GUIDELINES FOR THE DEVELOPMENT OF A PROJECT WITH INDUSTRY. Electronic Industries Foundation, 2001 Eye St., N.W., Washington, D.C. 20006. \$14.50.

COST CONTAINMENT AND COST BENEFIT ANALYSIS IN EMPLOYEE COUNSELING PROGRAMS: AN ANNOTATED BIBLIOGRAPHY. Industrial Social Welfare Center, Columbia University School of Social Work, 622 West 113th St., New York, NY \$2.50.

COMMENTARY

(Continued from page 21.)

negative aspects of accessibility at the Smithsonian, with possible suggestions to make a visit by a person with a handicap more enjoyable. For example, in talking about the National Zoo, Mr. Brubeck gives the impression that the only obstacle to a visit is the size—that's not so, no matter how strong a person is, if he/she is in a manual wheelchair the National Zoo is inaccessible. One has to have an able-bodied companion because of the steepness of the hills. **Kate E. Coleman**, RESPOND, Inc. (Resource to Encourage Services to Provide for the Ongoing Needs of the Disabled), New Haven, Connecticut.

THE BLIND WOMAN OF THE 80's:

Her Choices And Chances

Eunice Fiorito

The woman of the 80's, whether blind or sighted, is literally and figuratively a daughter of the previous decades. In my own life experiences, I can see trends and developments that parallel those in feminine society as a whole: the movement toward more independent action, striving for greater equality, and the recognition of individual strengths and abilities. While women in general have been progressing through the years, we who are blind have not come quite as far, simply because we *are* blind.

Before going further, I should explain that the word "blind" has different meanings for us and for the majority of our nonblind fellow citizens. We know that blind means only the physical inability to see and that this inability may range anywhere from total to comparatively moderate. However, to most sighted people "blind" also carries with it the connotations of dependent, weak, incapable, sometimes even deaf or retarded. It is these misconceptions and empty generalizations, not our disability, that isolate blind people and frustrate our efforts to succeed. Add to this the burden of being a woman in a world dominated by men, and our position becomes more understandable.

Though we may not have kept pace with our sighted sisters, blind women

have moved forward in the past 30 years. One indication of this is the variety of occupations we are now "permitted" to consider. When I entered college in the 50's, blind women were expected to pursue degrees in social work, teaching or one of the rehabilitation professions. These fields are fine and respectable, of course, but not all blind women are suited to them. And the galling factor was that our career choices were often imposed on us by the rehabilitation system supposedly established to help us become independent. While still far from perfect, the present system does allow us more flexibility to explore our interests and capabilities. In addition, we now have role models who are setting examples and breaking new professional ground for us. I know one blind woman who is a mathematician and another who is a chemist. Others are computer specialists, lawyers, writers, and psychologists. Not only are these women succeeding in their chosen fields, but, thanks to improved communication, younger women are learning of their success and taking inspiration from it.

Wider opportunities for blind women are, to some extent, part of a general pattern involving all women and minority groups. Recent years have seen a slow but steady breakdown of stereotypes. We are no longer sur-

prised to hear of black physicians, Hispanic business leaders or female judges. The phrase "equal opportunity" is now readily — if not always eagerly — included in the help-wanted ads. The drive to eliminate discrimination in employment began with the black civil rights movement of the late 50's and early 60's. The protective legislation resulting from that drive eventually expanded to include ethnic minorities, women, and even disabled people.

Society did not drop its age-old prejudices of its own altruistic accord. Rather, it reacted to the undeniable strength of mass movements organized and directed by persons whose lives had been blighted by bigotry and whose personal growth had been stifled by traditional attitudes. Marches, boycotts, and media campaigns demonstrated to employers that their discriminatory practices would no longer be tolerated; and these same efforts led Congress and a number of state legislatures to make such practices subject to criminal penalties. The lesson here is that conditions began to improve for women, minority groups, and handicapped people only when those most affected organized themselves to take charge of their own destiny.

A similar prescription for success can be implemented by each individu-

al, and the earlier the better. By that I mean that every blind woman, regardless of age, should participate as fully as possible in the planning and direction of her education, training, and career development. It will not be easy. For centuries, society has expected us to be nice little girls or demure young ladies who accept without question decisions made *for* us by our parents, teachers, and counselors. And we must admit that for centuries we have been doing just that, thus telling society that its beliefs are well founded. We must act now, collectively and individually, to combat and correct this false idea. Though current conditions may foster greater emphasis on our individual strengths, we are still in a period of transition. Vestiges of past dependence still keep us vulnerable to the whims of the nondisabled males who continue to control the economic progress of women in general.

Unfortunately, no one has yet produced a foolproof formula that will lead to maximum independence and substantial earning power. The economic, social, and political factors that influence our lives are variable at any time and even more unpredictable as we move deeper into the decade of the 80's. We can, however, point out certain basic elements necessary in any life plan but absolutely vital when the person doing the planning is disabled. These essentials were once described to me as "the three P's: Preparation, Persistence, and Performance".

Preparation is like the foundation of a building. It must be strong and carefully planned, or the structure rising from it will not last long. Every blind woman who has applied for a job or faced the prospect of being the only blind student in school knows the demands that are made of us. Errors and missteps that might be over-

looked if committed by nondisabled coworkers or classmates are immediately blamed on our blindness. Therefore, we must be over-prepared. In employment situations, this means knowing the field as thoroughly as possible, defining the problems that might be caused by a lack of sight, and being ready with workable, inexpensive solutions. Reaching this level of preparation may involve taking extra courses, getting a graduate degree, seeking part time or volunteer work in related occupations, discussing possible pitfalls with other blind persons, or perhaps agreeing to serve a short period of apprenticeship or probation. Of course, this is most important for the woman setting out to land her first job, but it is equally applicable for anyone attempting to change careers or reenter the job market after a long absence.

To continue the metaphor, if preparation is the foundation of a career structure, *persistence* is the key that will open the door. And we learn to use that key through early and continued practice. Traditionally, blind women do not argue with those who advise and guide us. Custom directs us to accept the path of least resistance and expect to be told what to do and when to do it. As Director of the Mayor's Office for the Handicapped in New York City, I frequently encountered blind girls who had excellent typing and other skills but who had no idea how and where to apply them. Obviously, these girls had been enrolled in this or that course and told to come to our office for placement assistance. They expected my staff to tell them where they should work. Though well prepared for certain types of employment, these young women had not developed a plan for pursuing the kind of work that matched their goals and capacities. As students, blind girls should begin

expressing their desires and assisting their parents and counselors in determining the course of study they will follow and the career they will eventually seek. Though this could be part of the preparation outlined earlier, I include this recommendation under persistence because it will help develop the assertive behavior necessary for the pursuit of a chosen career.

The most frequent advice given to jobseekers is the familiar: "If at first you don't succeed, try, try, again." Blind women must be ready to multiply and continue multiplying the number of tries. Being both blind and female may put her career hopes in double jeopardy, but she must remember that, in most cases, an employer's negative response has nothing at all to do with her qualifications. After repeated rejections, she may begin to doubt herself. However, if her preparation is solid, she can be confident of her ability, and her persistence will finally be justified.

Performance needs only a bit of explanation. As stated earlier, handicapped people in general and blind women in particular are subjected to higher than average standards. Employers are quick to believe that anything less than superior performance proves that a blind person cannot do the work. However unfair this may be, a blind woman must be more diligent, more productive, and more able than her able-bodied colleagues.

This discussion has concentrated on the individual woman because, after all, she must accept responsibility for her actions and decisions. Because of the success of the civil rights, women's and disability rights movements, she is now freer to act and decide for herself. In doing so, she may look for assistance to another legacy of the 60's and 70's. I refer to the increasing number of support

groups and what has come to be called networking. In my college days, I frequently felt that I was the only blind student who had ever had to deal with charts and graphs, insensitive professors and long, lonely weekends. I was reluctant to reveal my feelings of inadequacy to my blind friends. Today, groups are organized for the very purpose of discussing such feelings and dispelling the isolation they can bring. Support groups are not yet as prevalent among blind women as among women in general. As one who has experienced their benefits, I urge the establishment of such groups to aid young blind women just entering the world of work, older women (who form the largest segment of our population group), and young girls still in the early stages of preparing for independent lives.

Career choices for the blind woman of the 80's will not be as limited as in past generations. The achievements of her role models have guaranteed that. However, the number of her opportunities to work in a chosen career will be dictated by political and economic forces beyond her control. With proper preparation, stubborn persistence, superior performance and the support of her sisters, she can and will succeed.

Ms Fiorito is Acting Special Assistant to the Associate Commissioner, RSA. This paper was presented at a conference entitled "Career Choices for Blind Women in the 80s" at LaGuardia Community College, New York City, in November 1982.

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Disabled Woman Receives Award And Grant Support

The Wonder Woman Foundation honored 18 American women recently who contributed significantly to society and had overcome internal struggle.

Harriet Bell was one of these women. The award, plus a grant to continue her work, was the highest of its kind ever given to a disabled person.

Mother of three small children, she contracted polio in 1954, 6 months before the Salk vaccine became available, and became quadriplegic.

Goldwater Memorial Hospital, Roosevelt Island, became her home for the next 25 years. The hospital was virtually cut off from the rest of the world. Patients were referred to as the three F's—no funds, no friends, no family. It was a fight for Bell to see her children.

Bell, with other residents at the hospital, banded together to fight for the rights everyone takes for

granted— seeing your children, voting, having enough money to buy personal needs, such as toothpaste, shaving cream, and razor blades.

When a patient council was started, Bell was elected president four times. The council became a vehicle for effective political action in the mid 1950's. As the Civil Rights movement gained momentum in the 1960's, residents at Goldwater Hospital felt that their dreams and aspirations could also become realities. They began to work towards self-determination.

Bell contributed to the development of the Patient's Bill of Rights distributed by the NYC Health & Hospitals Corporation.

More recently Bell's concerns have turned to the needs of polio survivors. Individuals who had polio during the epidemics from 1946 to 1956, began reporting symptoms such as shortness of breath, muscle weakness, extreme fatigue, pain and interrupted sleep patterns. These, as yet, have been unexplained.

(Continued on Cover III.)

BABY DOE

(Continued from Cover II.)

age." He said, "The easiest thing would have been to defer, let somebody else make that decision." Oh? Someone had to deliberate about whether or not to starve the baby? When did it become natural, even necessary, in Indiana for parents to sit around debating whether to love or starve their newborns?

The lawyer said it was a "no-win situation" because "there would have been horrific trauma—trauma to the child who would never have enjoyed a—a quality of life of—of any sort, trauma to the family, trauma to society." In this "no-win" situation, the parents won: The county was prevented from ordering surgery; prospective adopters were frustrated; the baby is dead. Furthermore, how is society traumatized whenever a Down's syndrome baby is not killed? It was, I believe, George Orwell who warned that insincerity is the enemy of sensible language.

Someone should counsel the counselor to stop babbling about Down's syndrome children not having "any sort" of quality of life. The task of convincing communities to provide services and human sympathy for the retarded is difficult enough without incoherent lawyers laying down the law about whose life does and whose does not have "meaning."

The Washington Post headlined its report: "The Demise of 'Infant Doe'" (the name used in court). "Demise," indeed. That suggests an event unplanned, even perhaps unexplained. ("The Demise of Abraham Lincoln"?) The Post's story began:

"An Indiana couple, backed by the state's highest court and the family doctor, allowed their severely retarded newborn baby to die last Thursday night . . ."

But "severely retarded" is a misjudgment (also appearing in the *New York Times*) that is both a cause and an effect of cases like the one in Indiana. There is no way of knowing, and no reason to believe, that the baby would have been "severely retarded." A small fraction of Down's syndrome children are severely retarded. The degree of retardation cannot be known at birth. Furthermore, such children are dramatically responsive to infant stimulation and other early interventions. But, like other children, they need to eat.

When a commentator has a direct personal interest in an issue, it behooves him to say so. Some of my best friends are Down's syndrome citizens. (Citizens is what Down's syndrome children are if they avoid being homicide victims in hospitals.)

Jonathan Will, 10, fourth grader

and Orioles fan (and the best Wiffle-ball hitter in southern Maryland), has Down's syndrome. He does not "suffer from" (as newspapers are wont to say) Down's syndrome. He suffers from nothing, except anxiety about the Orioles' lousy start.

He is doing nicely, thank you. But he is bound to have quite enough problems dealing with society—receiving rights, let alone empathy. He can do without people like Infant Doe's parents, and courts like Indiana's asserting by their actions the principle that people like him are less than fully human. On the evidence, Down's syndrome citizens have little to learn about being human from the people responsible for the death of Infant Doe.

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(Continued from page 32.)

Bell, with Florence Weiner, established a Polio Information Center at 510 Main Street, Roosevelt Island, NY 10044. Together they created and distributed a post-polio questionnaire to find people who had polio, and determine the problems, needs, and resources throughout the United States.

To be part of the study, send a stamped, self-addressed envelope to: Harriet Bell, Polio Information Center, 510 Main Street, Roosevelt Island, NY 10044.

Training Center Teachers Placement, Job Development

The New York University Department of Rehabilitation Counseling has established a center to train its students in job placement and career

development for people with disabilities.

Money for the center—which will provide eight students with traineeships at various agencies, full tuition and a monthly stipend—is part of a grant received by the Human Resources Center from the National Institute of Handicapped Research.

Under terms of the grant, NYU is responsible for integrating the HRC's research findings into educational programs for training rehabilitation counseling students in the theory and practice associated with placement and career development for people with disabilities.

The eight master's degree students in the rehabilitation counseling program will be assigned to internships in agencies that have job placement for the disabled as a primary function. The students will spend approximately 600 hours over two semesters in the agencies.

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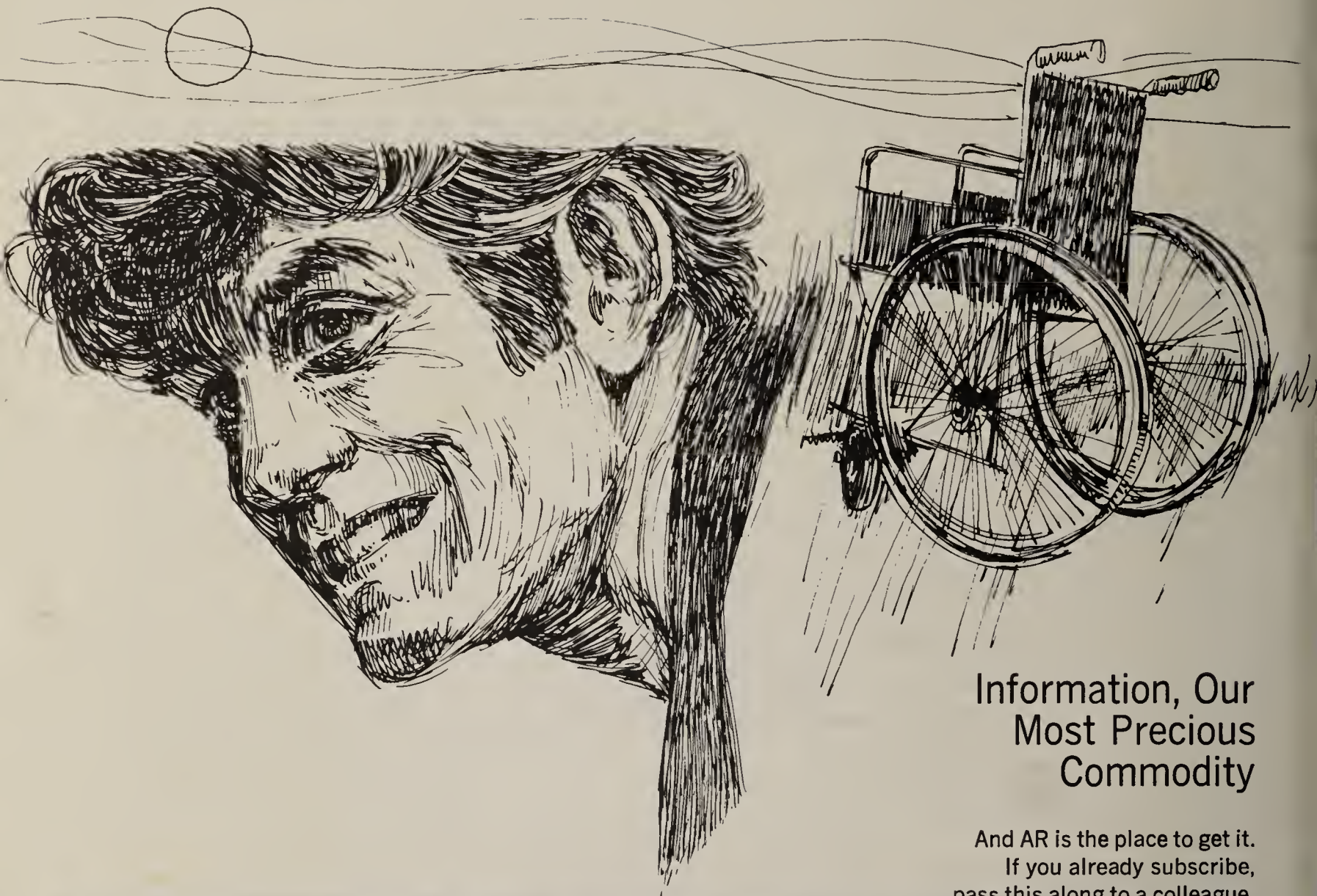
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AMERICAN REHABILITATION

- Placement Survey
- Stigma
- Independent Living
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The following poem was written by John David Williams for his father, Boyce, and read on August 6 on the occasion of the father's retirement from 38 years of government service to the deaf people of this country. We feel it says a lot about the man and about the world of deafness:

BEYOND SILENCE

Deafness is soundless sight
Music frozen in paper
Air with no sound
Rhythm with no beat
Rushing bodies in the street
Bumps of surprise
A tap of disruption.

Mouth and lips move against the
Glass of isolation.
Words emerge: Life's stream of bubbles
Crystal spheres, hollow of meaning,
Break and ripple at the surface of reason,
While silent, on the sandy floor,
Deafness sways in mute incomprehension.

Invisible to most
Embarrassing to some
Deafness hides from the social stare
Huddled in ghettos from the listening ear.
Talents wither in the soundless air;
Each hope blooms and dies in dumb despair.

What once seemed only a Quixotic joust
To turn the Public Ear
And see the Deaf as fellow men
—One Deaf man tried for forty years
to show the world the Deaf belong.
As humans do, in the Grand Hall of all creation.

No more must the deaf man
Stand outside, on tiptoes,
To see life's grand commotion
But step up to the dance of life
And sing the song of strong emotion.

My Father within his own
Soundless world and intense frustration,
Smashed the locks on a million
Cells of desolation.
He set free, by single purpose
And tenacity of mind
The human force locked up in
A silent scream:
He leaves the deaf
Not wishing
But living
The impossible dream.

AMERICAN REHABILITATION

Volume 9, Number 4

The weakest ink is better than the strongest memory.

Oct-Nov-Dec 1983

-
- | | | |
|---|--|--------------------------------|
| 3 | Sampling Of Placements In Foodservices | A. Philip Nelan, F.S.C., Ph.D. |
|---|--|--------------------------------|
-
- | | | |
|---|--|---------------|
| 7 | Santa Clara County Ranks No. 1 In Goodwill | Steve Kaufman |
|---|--|---------------|
-
- | | | |
|----|--------------------------------|-----------------|
| 12 | Celluloid Images Of Disability | Timothy Elliott |
|----|--------------------------------|-----------------|
-
- | | | |
|----|--|----------------|
| 18 | Independent Living—Cost-Effective In Maine | Denise Richard |
|----|--|----------------|
-
- | | | |
|----|---|------------------|
| 23 | Accretiveness—A Concept Of Independent Living | Glenn S. Leavitt |
|----|---|------------------|
-
- | | | |
|----|----------------------------|----------------|
| 24 | Barriers To Blind Progress | Eunice Fiorito |
|----|----------------------------|----------------|
-
- | | | |
|----|--|--------------|
| 26 | National Institutes of Handicapped Research
Functional Electrical Stimulation | Emily Cromar |
|----|--|--------------|
-
- | | | |
|----|--|--|
| 30 | Center Staffed By Disabled Professionals | |
|----|--|--|
-
- | | | |
|----|-------------------------|-----------------|
| 31 | Sexuality and Arthritis | Peter G. Mathon |
|----|-------------------------|-----------------|
-

DEPARTMENTS

- | | | | |
|----|------------------|----|----------------------------|
| 2 | Topic Of State | 16 | News, Notes, Announcements |
| 9 | Language Used | 29 | New Publications |
| 10 | Report Resources | 32 | Commentary |

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TOPIC OF STATE

NY To Serve Migrant Workers

The New York Office of Vocational Rehabilitation has established a project for providing services to handicapped migrants and seasonal farmworkers and their families. This project, established by a grant from the Federal Rehabilitation Services Administration, under special projects for the severely disabled, will be operated through OVR's Buffalo, Rochester, Poughkeepsie, and Albany District Offices. A project coordinator will provide technical assistance and will have responsibility for developing, preparing and monitoring program goals, statistics, and cooperative relationships. The coordinator, under the supervision of the Upstate Regional Director of Field Operations, will work toward developing a service delivery system which will have the administrative program identity, statistical base, and case service capacity necessary to become an integral part of OVR's own program.

In addition to the project coordinator, project funds are providing full-time vocational rehabilitation assistants in Buffalo and Rochester, as well as a vocational rehabilitation counselor in Albany. The Poughkeepsie District Office will be providing a full-time vocational rehabilitation assistant as part of the continuing emphasis on services to migrants and seasonal farmworkers. OVR is also demonstrating its active support for this program by provision of support staff and halftime vocational rehabilitation counselors through the Poughkeepsie and western New York offices.

OVR expects to become involved as a participant in the federal tracking system for migratory workers coordinated through Virginia's Department of Rehabilitation Services. Active participation in the New York State Interagency Coordinating Committee on Migrant and Seasonal Farmworkers, and close cooperation with the Education Department's Bureau of Migrant Education and Rural Employment Representatives from the Department of Labor, as well as with other key state agencies, such as the Departments of Agriculture and Markets and Health, will be important to the project's overall success.

Serving Deaf Clients In The Rubella Bulge

Many more young adults who are deaf will soon be seeking post-secondary educational and/or rehabilitative services as a consequence of the rubella epidemic which swept across the United States from 1963-65. This population has been dubbed, "the rubella bulge" by rehabilitation professionals. In California, more than 10 times as many infants were born deaf between 1963-65 than in years prior to 1957. Their full impact is expected to be felt by rehabilitation agencies over the next six years.

Rubella, better known as German measles, is a common vital infectious disease. It generally runs its course with no serious side effects. However, in 1941, a correlation between congenital cataracts and maternal rubella was noticed by an Australian physician named Norman Gregg. Two years later, the connection between maternal rubella and hearing impair-

ments was made (Annals of Otology, Rhinology and Laryngology, 78(5), 1969, 917-928).

In 1969, a vaccine for rubella became available for widespread use. This preventive measure is now recommended to women of child-bearing age who have not had the disease, since pregnant women appear to be particularly susceptible to the rubella virus if they have not already developed immunity to it. Mothers with rubella in the first trimester of pregnancy risk a 50% chance of passing the infection to the fetus, the most dangerous period in terms of risk of fetal infection and the damage done by such infection.

Among those born with congenital rubella as a result of the 1963-65 epidemic, 60% have less than a 90 I.Q. and 20% less than a 70 I.Q. Thirty-one percent (8,000) are estimated to be deaf and an additional 3,600 deaf-blind. There is also an increased incidence of other disabilities in this group, since no system in the body escapes pathology caused by the rubella virus. In addition to disabilities such as mental retardation, cerebral palsy, and other impairments of the central nervous system, the infection results in deafness, blindness, cardiac abnormalities, and impairments of the entire body system. The rubella virus can remain active in children after birth, and has been known to cause damage to the pancreatic islets, resulting in diabetes mellitus.

Due to the multiplicity of handicaps observed in children with congenital rubella, there are special considerations for rehabilitation professionals who may provide services to this group. As previously undiagnosed disabilities emerge, counselors need to be aware of the full scope of functional limitations which may im-

(Continued on page 6.)

A Sampling Of Placements In The Foodservice Industry

A. Philip Nelan, F.S.C., Ph.D.

More than 4,800 people with impairments have been identified as placed in foodservices competitive employment during the 12 months before July 1, 1983. This data represents the response of 275 vocational rehabilitation services, agencies, and training facilities in 49 states to a survey by the National Restaurant Association's Projects With Industry (PWI) program to learn of their placement experiences.

The number of responses to a single appeal mailed to more than 600 agencies probably represents only a sampling of placements in so large an industry of about 560,000 eating places nationally (restaurants, lunchrooms, cafeterias, hotels, motels, clubs, colleges, hospitals, etc.), an industry with an acknowledged need for table employees.

One might speculate whether 50,000 units have a single employee with a disability. However, the data of the survey does afford evidence that foodservice employers recognize that qualified people with impairments can fill and hold jobs in the industry. Many more potential employers must be educated and persuaded.

However, the results of the survey suggest a growing understanding and openness on the part of foodservice operators to the potentials of the im-

paired population. On the other hand, the placement personnel's experiences afford insights as to the industry practices in hiring people with disabilities in significant numbers, as well as some insights into the reasons for the successes of rehabilitation facilities in representing their people.

Table 1 adopting the Census Bureau's regional division of the country, gives a comparative overview of placement activities in the various sections of the country. The regions are listed in the order of successful placements, adjusted to the regional populations. The right hand column records the estimated number of foodservice units in each region. The table lists the states of each region, the total population, and its percentage of the country's total population (1980 Census), the number of placements, and the relative standing of each region in point of its total placements. A number after a state's listing indicates over 100 placed.

The survey did not aim to discover the various types of impairments represented among the recorded employed. Nor did it question the source through which a facility or agency made contact with the industry nor about the methods pursued by job developers and placement counselors in discovering favorable employers and

jobs. Much might be analyzed, too, about training to qualify candidates as job-ready.

Employers and Jobs

The data shows that a variety of providers across the board have opened opportunities to job-ready people: small local coffee shops, cafeterias, lunch rooms, full service and fast food operations in single owner establishments, and the largest chains. Placements have also been made in hotels, motels, clubs, hospitals, colleges and schools, and nursing and retirement homes.

The large chains or corporations may extend nationally or they may be localized in a few states of a region. In some, a company policy encourages managers to look to the benefits of employing job-ready people through rehabilitation services. The effect of such a formal policy can be traced throughout many parts of the country, as illustrated by employment practices in Saga, ARA, Seilers, McDonald's, Burger King, Bonanza, Morrison's, Hardees, Mr. Steak, Vallee's, Friendly's, Ponderosa, Kentucky Fried Chicken, Wendy's, Stouffer's, Furr's Cafeterias, Denny's, Red Lobster, Western Sizzlin, Steak and Ale, Roy Roger's, Pizza Hut, Dunkin Donuts, Taco

Table 1

<i>Region</i>	<i>Pop. Million</i>	<i>% Natl. Pop.</i>	<i>Number Placed</i>	<i>Index</i>	<i>Est. Foodservice Units—1000's</i>
<i>West South Central</i>					
AR, LO, OK—242, TX—843	24,577	10.6%	1117	100	58.3
<i>South Atlantic</i>					
DL, DC, FL, GA, MD—149, NC, SC—420, VA—534, WV	38,127	16.5%	1350	.85	84.5
<i>West North Central</i>					
IO, KA, MN, MO—220, NE, ND, SD	17,399	7.5%	393	.50	46.3
<i>East South Central</i>					
AL, KY, MS—238, TN	14,987	6.48%	341	.49	27.3
<i>New England</i>					
CT, ME, MA, NH, RI, VT	12,448	5.3%	209	.38	34.1
<i>Mountain</i>					
AZ, CO, ID, NV, NM, UT, WY	11,976	5.18%	178	.33	28.3
<i>East North Central</i>					
IL, IN, MI—356, OH, WI	41,949	18.1%	585	.31	101.4
<i>Middle Atlantic</i>					
NJ—157, NY—207, PA	36,730	15.89%	412	.25	92.1
<i>Pacific</i>					
AK, CA, HA, OR, WA	32,815	14.2%	234	.16	87.3

(If all the operators employing the 4,500 people with disabilities this last year availed themselves of the Targeted Job Tax Credit (TJTC), the total tax benefits of 50% on \$6,000 salary for each would amount to \$13,500,000 to the industry. The following year for these same 4,500 employees the operators would realize 25% on \$6,000 salary, an additional \$6,750,000—\$20,250,000 in the overall total, not to cite next years benefits from hiring an added group of people with impairments.)

Bell, Taco Hut, and Ogden.

Also, a wide selection of hotel-motel chains have responded by employing qualified people with impairments in their kitchen-dining room operations, as well as in other services. The management and personnel people have been sensitive to the potentials of trained people from vocation rehabilitation facilities, notably in the following chains: Marriott, Hilton, Hilton Inns, Sheraton, Holiday Inns, Radisson, Ramada Inns, Quality Inns, Hyatt, and Howard Johnson.

The types of jobs performed by trained persons with disabilities may appear surprisingly varied. The acquired skills and abilities of trainees and their adjustments to participating successfully in the work force counts, not their disabilities. A seen or unseen disability does not disqualify a person from competitive employment. So the reported jobs held include not only the usual entry level types, but also kitchen aid or helper, cook's helper, counter clerk, inventory-control, stock person, pizza maker, fry cook, salad maker, sand-

wich maker, bartender, food preparation, serving clerk, baker's helper, utility person, line server, maintenance, griddle attendant, assistant cook, donut maker, waitress, cashier, hostess, assistant manager, and owner. The National Restaurant Association's program stresses the importance of discovering a career in the industry through the experience of whatever job one starts at.

Region/State Results

A glance at the table of placement-performance by regions reveals that

few states represent 100 or more placements. Incidentally, placements were not made necessarily in areas with the greatest number of eating places. The leading state performances numerically as reported are: Michigan, South Carolina, Missouri, New York, Virginia, Maryland, Oklahoma, Texas, New Jersey, and Mississippi. In Texas a unique instance exists where 175 people with impairments, trained at the Individual Development Center at Wichita Falls, are competitively employed at Sheppard Air Force Base and are doing 75 percent of the hourly work in all phases of the commissary operations to serve meals to the entire base personnel.

The outstanding, single state report is that of South Carolina. The state divisional supervisors of vocational rehabilitation identified to the Commissioner's office 420 placements in specific jobs in the industry during the preceding 12 months. This performance in a state with a population of 3.2 million, or 1½ percent of the country's total population (1980 Census), significantly indicates the potential of 28,000 placements in foodservices nationally if each state could post the same rate of placements. Not less important is the observation that the industry can count fewer than 7,500 units in South Carolina.

In contrast is the fact that the regions of the country having the largest populations and the largest number of foodservice units stand last in the comparative table.

The performance by the South Carolina Restaurant Association in hiring people with disabilities augurs well for the process in other regions of the country. An important factor is that reports from only six other states are so complete. Notwithstanding, the industry's response elsewhere should

grow to being close proportionately to the findings in South Carolina. We might speculate about what this would mean in employment of impaired people where the industry approximates 45,000 units as in California and New York; 35,000 in Texas; 30,000 in Illinois; 25,000 in Florida, New Jersey, and Ohio, as against only about 7,500 units in South Carolina. Here alone more than 12,000 placements would be recorded.

Success In Placement

Outstanding successes in the placement of people with disabilities in foodservices is not haphazard. It implies that rehabilitation services have a clear grasp of management organization, goals, and means to its outcomes as a strong business. Moreover, success grows out of well developed close relations of training programs with the operators of businesses. Being open to understanding how foodservice business is run and making sure to give operators of establishments clear understanding of all aspects of rehabilitation services, the functions of agencies and facilities is crucial. As an organization, either knows little about the other.

The key is establishing an active and thoroughly engaged advisory council of foodservice managers, owners, etc. to the skills-training operation. The businessman should have the opportunity to learn the goals, means, outcomes, and roles of a training facility. They usually cooperate generously if asked to help in drawing up a curriculum of training, overseeing its methodology, having a role in deciding the job-readiness of trainees in point of their work adjustments and social adjustments, as well as their skills acquisition.

Out of such relationships between

the industry and training programs, on-the-job training sites develop, opportunities for establishing "contract work stations" (also named "Crews in Industry" programs) can unfold, and perennial problems of transportation and hours of work can be resolved. The industry's demonstrated readiness to assist in community services by employing qualified people with impairments invites vocational rehabilitation services to explore more actively this potential for placements.

Promoting The Program

The National Restaurant Association's program seeks to open to employers the benefits of employing person with disabilities who are trained and qualified. Universally recognized benefits are: such employees, with extremely few exceptions, have unsurpassed attendance records; they are stable, motivated, reliable, and most importantly, they are loyal. Their safety record is better than average (U.S. Labor Department Survey); they have no effect on insurance cost (U.S. Chamber of Commerce).

The program is a means of bringing the industry and vocational rehabilitation services together in mutual understanding and cooperation. Opportunity is taken to introduce the sectors to each other through meetings of the state associations and chapters of the industry, exhibiting the program at state food shows, coordinating relations between operators and a training facility in a given locality and also through the national organizations of rehabilitation (Rehabilitation Services Administration, Association of Rehabilitation Facilities, Mainstream, National Rehabilitation Association, National Institute of Mental Health, Association of Retarded Citizens, President's Committee on Employ-

ment of Handicapped, the States' Governor's Committees, etc.).

Also important among our promotional activities is our dissemination of materials about training, as well as linking various successful innovations in various parts of the country. Through the industry we have occasion to make appearances and presen-

tations at meetings of allied hospitality groups and to participate in their state and regional seminars. The core resource for promoting the program is the National Restaurant Association's operational arm through its public relations, publications, legal and research departments, and especially through the hovering influence of the

Board of Directors to whom the program is reported by the overseeing Human Resources Committee and advisory council three times a year.

Brother Nelan is a Christian Brother and Director of Handicapped Employment Programs, National Restaurant Association, Washington, DC.

TOPIC OF STATE

(Continued from page 2.)

pact upon rehabilitation planning. Keeping the possibility of multiple disabilities in mind will ensure an appropriate diagnostic evaluation leading to successful placements for counselors working with these clients.

Gary Johnson, in *Rehab Review*, California Department of Rehabilitation.

Ohio Center Goal Is 80 Percent Job Placement

"Word processing is the up and coming thing," believes Jim Cunningham, director of computer programming for the Central Ohio Rehabilitation Center (CORC) in Columbus. The center, a division of Goodwill Industries, also trains disabled people to work in jobs including those in the areas of computer programming and operations. In the Fall of 1982, it was awarded an Ohio Rehabilitation Service Commission establishment grant (E grant) to update its existing business office skills training program, to purchase word processing equipment, and add that area of study to the CORC curriculum. The center's share of the funding was \$3,881, which was matched by \$15,524 in federal funds, through RSC. CORC is no stranger to RSC assistance—it has received other grants in the past.

"Basically, we wanted to revamp our existing programs," said Cunningham. "We knew that grant money was available, and everyone at RSC was very supportive, since they knew there was a great market out there for word processors." Referrals to the course are made through the Bureau of Vocational Rehabilitation. Cunningham said that word processing work, which can be compared to "computerized typing," requires a fairly high initial typing ability. If, however, an applicant cannot type the beginning 40-45 words per minute, the person may begin a regular typing program and gear toward the word processing course.

All of the E grant money was used to purchase modern Wang equipment. "We were able to get a system because Wang was running a year-end sale," said Cunningham, "which was 'buy one, get one free'!" The type of equipment was of some importance, Cunningham noted, because many employers specify knowledge of the Wang processors, "but all business people do agree that it's not the equipment that makes word processors, it's what you teach." The primary focus of the CORC course, he said, "is on grammar, spelling, and proofreading. Many companies will hire someone with no word processing experience if they have good grammar and spelling, but it does look really good if a person has Wang on the resume."

The initial class of trainees began

actual word processing training on April 11. Prior to that, the students had spent several weeks polishing their typing skills. There is only one man in the first class, but "I think we will be attracting more men," Cunningham said. "I think this is a good job for a man."

CORC is a member of both the Wang International Information Group and the International Information Word Processing Association, national organizations which include business professionals. The latter group, said Cunningham, expressed special interest in the training of disabled people for word processing careers because of their job stability. Both organizations have extended much professional help to the new program. Additionally, CORC has a business advisory committee, comprised of business-people willing to contribute their expertise to the center's efforts.

The entire word processing course is 4 months long and includes business math, spelling, grammar, and English. After two months, the math is replaced by a proofreading course. Students spend 6 to 8 weeks actually working on word processor concepts, all the while continuing to type and raise other business skill levels. The courses are taught by one faculty member, who is assisted by a vocational training aide. Each student also has his or her own case manager, to help with individual concerns. The

(Continued on page 22.)

Santa Clara County Ranks No. 1 In Goodwill

Steve Kaufman

In a sprawling facility on a quiet street in San Jose, hundreds of employees are working on a staggering array of projects. Among other things, they are twisting electronic cables into shape, collating pages, reupholstering furniture, machining parts and printing pamphlets.

These and other activities generated \$8 million in revenues in 1982—a 16 percent increase from 1981—and the brass is aiming for the \$10 million mark in the next couple of years. “We keep moving forward,” boasts Pat Ceglia, who oversees production here.

Welcome to Goodwill of Santa Clara County, which is now ranked as the best Goodwill among 221 in the world. More than 99 percent of its operating budget is funded from revenues from its contract production operations and retail store sales. That compares with an average of 94 percent at all Goodwills.

Perhaps more noteworthy, this Goodwill placed 154 people in outside jobs last year, or 89 percent of the graduates of its vocational school.

In San Francisco, in contrast, Goodwill placed only 12. The Goodwill in San Diego, a bigger city, placed 22. “In nine out of 10 cases, the Goodwill in San Jose places more people than Goodwills in other cities,” says Robin Star, a spokeswoman for Goodwill Industries of America, Goodwill’s parent organization.

Understandably, such comparisons excite Andy Liersch, the reed-thin, gray-haired president and chief executive of Goodwill of Santa Clara County. “Los Angeles has been ranked No. 2 three times in the last five years,” he says. “But to my knowledge, a California city has never before placed No. 1.”

The purpose of Goodwill is to provide employment opportunities for the disadvantaged and handicapped. But Goodwills are expected to earn the money they need, not subsist on handouts. Any surplus is pumped into a vocational training school and other worthwhile ventures.

“We manage and operate like a business with a business plan, with full accountability at all levels,” Liersch asserts.

The local Goodwill was falling into bankruptcy in 1976, however, and that prompted the search for a new leader and the hiring of Liersch, who had extensive management experience in the semiconductor industry. In one post, he was director of military and high reliability production at Signetics Corp. of Sunnyvale. Liersch, who is 46, was picked from a field of nearly 75 applicants.

“Andy obviously fit the qualities we were looking for,” says Jan Passmore, past chairman of the Santa Clara County Goodwill and a member of the three-man committee that hired him. “We were looking for a business man who had the qualities to run Goodwill as a business so that we could provide more opportunities for people with handicaps.”

An excellent measure of Liersch’s success has been the growth of Goodwill’s contract production operations, or those job shops that machine parts, reupholster furniture and provide other services competitively. These produced 54 percent of the organization’s revenues last year, compared to

only 10 percent at the average Goodwill.

Santa Clara County’s Goodwill did work for 112 companies in 1982, compared to 12 the year that Liersch came aboard, and they included the likes of IBM, General Electric Co., Hewlett-Packard Co., and Ford Aerospace.

Because 79 percent of Goodwill’s 520 employees are handicapped, no one here claims that these people are as productive as their counterparts in other job shops. Half of the handicapped have orthopedic disabilities, including missing limbs and severe back injuries. Others have emotional and mental problems.

“Many of our people can perform only one job,” says Vern Brinks, who supervises 47 people in Goodwill’s electronic subassembly operations. “In a regular shop, one person may be able to do 10 different jobs.”

Nonetheless, Goodwill competes successfully by putting more people on the same job—and subsidizing the shortfall in productivity. “Quality and service are the only things that a job shop has to sell,” says Ceglia, who is general manager of contract operations. “Companies aren’t going to give us work because we are Goodwill.”

“If you satisfy the customer, you are doing the job you were hired to do.”

Goodwill employees don’t fare badly, either. They’re paid at least the minimum wage, or \$3.35 hourly, and the average worker makes \$4.53 an hour. Some highly skilled workers, including machinists, furniture reupholsterers and carpenters, earn up to \$9.50 an hour.

Goodwill helps the handicapped in two ways. People who need jobs go to work immediately, and some eventually hone their skills enough to sell themselves into better-paying jobs

outside. Goodwill doesn't keep figures on this, but the number apparently is respectable.

Liersch says the organization will typically pay someone the minimum wage and train him as a solderer, then watch him move into industry for twice as much money. "Except for a core cadre of workers, our objective isn't to keep people in our production operations indefinitely," he says.

Those who can afford to live without a paycheck for a while are enrolled in Goodwill's vocational school, where they spend 18 to 46 weeks learning a marketable skill through a combination of classroom and laboratory training. The school trains people to become electronic technicians and assemblers, electro/mechanical draftsmen, secretaries, bookkeepers, clerks, and janitors.

When the economy is strong, electronic technician graduates seldom meet delays in finding work. "Our only problem has been convincing companies not to make our people offers before they finish their training," Liersch says.

It wasn't always this way.

Liersch's predecessor was the late Don Lathrop, a blind man who worked his way up from an interviewing position in the personnel department and served as executive director for 18 years. Problems snowballed during the end of his tenure. Some people were working for as little as 11 cents an hour, while others were trained as bookkeepers and placed in dishwashing jobs.

On some occasions, employees were told not to cash their paychecks for several hours because Goodwill didn't have the money in the bank to cover them.

"Don's aides made him see things the way he wanted to see them, not the way they really were," says Brinks, Goodwill's electronics sub-

assembly supervisor.

Adds Liersch: "Don got sucked into believing that everyone was stealing. There was some theft, but not to the magnitude he believed. He just became myopic over that issue."

The writing was on the wall by 1976. That year, Goodwill lost \$710,000 on \$3 million in revenues. In the second half of the year, losses were averaging \$85,000 a month. Accounts payable were six months late, and \$60,000 had been borrowed against receivables.

Goodwill, in short, was on the verge of insolvency. And it couldn't turn to the community for help because it had just raised \$750,000 in a major campaign to help pay for its new 149,000-square-foot facility on North Seventh Street.

Liersch went to work in October of that year and tackled the problems immediately. He persuaded major creditors to go along with Goodwill for another 90 days, borrowed an additional \$50,000 against receivables and eliminated an entire tier of management, or about two dozen jobs.

"One of the major problems here was communications," Liersch says. "If you went to a department head and asked him a question, you couldn't get an answer. He just wasn't close enough to his operation."

Liersch also focused his attention on Goodwill's contract operations. At the time, employees were pretty much limited to fixing broken bicycles, TV sets and toasters and repairing household furniture. Sensing a major opportunity in the electronic cable and harness business, Liersch spent \$160,000 on new equipment and bid on two research and development subcontracts at IBM and National Semiconductor Corp. of Santa Clara.

He won both, and that led to additional contracts from them and other

firms. "What this told the community was that Goodwill could meet IBM's specifications," Liersch says. "And by doing business with National Semiconductor, it showed that our prices were right."

Liersch also strengthened Goodwill's furniture reupholstery operations.

He switched the emphasis to commercial reupholstery work and snagged a job to recushion 6,000 secretarial chairs spread throughout seven floors of the Social Security Administration's regional headquarters in Richmond. Shortly afterward, Goodwill refurbished much of the furniture in the student union building at San Jose State University.

The list of accomplishments expanded as time went on. Liersch later streamlined Goodwill's retailing operations and turned store managers into aggressive salesmen. Goodwill now owns three of the seven stores it has in the area.

As revenues from the stores and contract operations climbed, Liersch turned his attention to expanding the scope and quality of the vocational school. The school now accommodates 116 students a day, twice the number it did in 1976, and the number of full-time instructors has climbed from five to 12.

Microcomputer-aided instruction was introduced five years ago. "I don't think any Goodwill in the country is as efficient or successful as we are," contends Passmore, Goodwill's ex-chairman, who remains with the organization as second vice chairman.

Mr. Kaufman is editor of the Business Monday section of the *San Jose Mercury News* and this article appeared in that paper on August 8, 1983. It is reprinted with permission of the author and the *San Jose Mercury News*.

Language Used or Used Language?

Ron Bourgea

As is evident above, the editorial "we" has been dropped in favor of specific author identification. This change of policy has come about as the result of increasing demands from readers for such a disclosure.

By way of historical perspective, the column began many years ago as a "sometime" filler (usually under 1/4 page) under the authorship of a former editor and continued by me when I became editor in 1973. The item attracted sufficient attention and interest to raise its prestige from a "filler" to a full time department in March 1976. (Besides, both the former editor and I had noted the need for such comment.) Since departments are not by-lined, this one was not, either; but, as the content shifted gradually from "observational" comment to analysis, the demand for identity increased. The demand was just.

Superabundance. Sue these words for nonsupport.

I notice a new wrinkle in the presentation of positive word, non-functional appendages (e.g., search the *available* literature). It is the "tandem" nonfunctional phrase, as in "the deadline for *completion* and issuance" and "the procedures have been *written* and distributed." If one meets a deadline and issues whatever, a reasonable assumption is made that "whatever" is also complete. Like-

wise, if a procedure is distributed, one can also reasonably assume that it has been written. In the latter case, unless there is utmost importance on delineating how the procedure was done (oral, written, telephonic, versified, etc.), the descriptors are not necessary (The written procedures have been distributed.).

Continuing the above: "There has been excellent cooperation and *interaction* between the units." We would honestly like to see a cooperation that does not involve an interaction. . . . "The system will be presented to the Commissioner for his *review* and approval." Without dereliction of duty, I can hardly contemplate approval without review.

Detailed analysis—an analysis looks at detail. To be sure, there are analyses that are more complete or less complete than others, but the connotation here is not an "in-depth" analysis, but an analysis of "parts" which is what an analysis is in the first place.

Careful Writing. Simple writing does not necessarily mean clear writing.

The non-Euclidean precept that the shortest distance between two points is a curved line may find its proof in the psychological as well as in physical measurement. In the latter case, I remember my college professor point-

ing out that a line drawn from point A on the equator to point B at the North Pole yields a curved not a straight line. In the realm of the psychological, the nuance is more discrete, but may display our subliminal adherence to the principle, based on our penchant for the roundabout construction (the curve) to get from point A to point B.

Here are two examples: "They have worked to develop a plan" and "the conference was designed to assist the attendees." In the first instance, what is wrong with "They have developed a plan," since, when one develops something, one must have worked to do it? In the second, "The conference assisted the attendees" is to the point unless the assistance was not a part of the design, in which case, the point of design would be stated. As originally given, the examples are non-Euclidean curves between points. In their second rendition, they go from point A to B in a plane, geometric line.

Pastiche. Grab bags are great in junk sales; they have no place in precise writing.

Constantly-continually—Although these words are used interchangeably, they nevertheless retain a fine-line differentiation that is refreshing to see observed: Where "constantly" has the connotation of straight-line action, "continually" suggests one or more breaks in the action, even when the action is of short duration. Thus, to say that a training program is constantly updated gives a negative implication to the program, whereas the continually updated program implies regular assessment that results in a progressively better or modern program, i.e., "constantly" connotes incessant need for revision while "continually" connotes only periodic need for updating.

REPORT RESOURCES

EMORY UNIVERSITY REGIONAL REHABILITATION RESEARCH AND TRAINING CENTER. (Grant #G008003042/NIHR). Executive Summary and Final Report of the Department of Rehabilitation Medicine in the School of Medicine, Emory University.

The overall goal of this Rehabilitation Research and Training Center (RT-6) has been to develop and implement programmatic research to advance evaluation, treatment, and prediction of treatment outcomes for rehabilitation clients with neuromusculo-skeletal impairments. A second goal has been to study related medical, psychological, and educational aspects which affect the rehabilitation of handicapped people. The objectives of these goals were three: 1) to improve the evaluation of client capability; 2) to improve therapy; and 3) to improve service delivery. Complementary program activities in training, dissemination, and research use were conducted.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

PSYCHOLOGICAL ADJUSTMENT AND CHARACTERISTICS IN RECENT SPINAL CORD INJURIES RELATED TO REHABILITATION OUTCOMES. (Grant #G008005821/NIHR). Final Report of the Department of Rehabilitative Services, Commonwealth of Virginia.

This psychosocial vocational project was designed to extend the effec-

tiveness of the National Spinal Cord Injury Data System in its efforts to find ways of reducing the cost of care for spinal cord injury and improving outcomes. A major emphasis on psychosocial aspects of rehabilitation was added to the then current research program of the National System. These new dimensions included extensive detailed evaluations to study the relationship between a considerable number of variables in the Rehabilitative Services Administration's national data base and to determine why psychological and social factors are related to the measures of educational-vocational productivity; social activities and the fulfillment of significant social roles; and long term maintenance of health and utilization of medical care.

To accomplish these purposes, a group of standardized published psychosocial tests and instruments especially designed to meet the needs of this research were administered to a selected group of clients. This study involved the measurement of certain traits and characteristics on a longitudinal basis as well as a cross-sectional basis.

For copies contact: Sharon McFarland, National and Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

REGIONAL REHABILITATION RESEARCH INSTITUTE ON ATTITUDINAL, LEGAL, AND LEISURE BARRIERS 1975-1981. (Grant #G008005333/NIHR). The George Washington University, Washington, D.C.

The purpose of this project was to provide research and technical assistance to rehabilitation professionals and the general public on attitudinal, legal, and leisure barriers faced by people with physical and mental disabilities.

This report describes work conducted from 1975-1981. Projects discussed include: a barriers assessment retreat with disabled consumers, development of a handbook on employment rights, development of a simulation game to facilitate communication between rehabilitation professionals and disabled people, preparation of the Barrier Awareness Series of publications, dissemination of attitudinal information to target audiences, a study to assess attitudes of rehabilitation counselors and clients toward each other, a national conference on recreation and disability, and a project on television portrayals of disabled people.

Conclusions of the project indicate that attitudinal barriers are the single, most insidious barriers that impair full integration of people with disabilities into society. Public awareness and education reduces these attitudinal barriers and fosters cooperation. A national effort needs to be made to ensure further work on attitudes and disability, especially in the areas of media portrayals, leisure and recreation, and sexuality.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

PSYCHOLOGICAL ADJUSTMENT AND CHARACTERISTICS IN RECENT SPINAL CORD INJURIES. (Grant #13-P-59127/NIHR). Final

Report of the Department of Rehabilitation Medicine, New York University Medical Center.

This project seeks to describe the multiple types of outcomes which emerge during the first two post-injury years in a group of individuals with spinal cord injury. Various types of data were collected at four points in time: four to twelve weeks post-injury, discharge from medical rehabilitation, one year post-injury, and two years post-injury. Four types of data have been collected: demographic, medical, psychosocial, and behavioral. Psychological data is collected through the administration of the MMPI. Behavioral data is gathered from structured interviews and by the administration of the Activity Pattern Indicators (API's) that were developed by the Rehabilitation Indicators Project. Through the multivariate analysis of this complex set of data it is believed an understanding of the process change associated with rehabilitation and quality of life (API's) during the first two years post-injury will be derived.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

FINAL REPORT OF THE MEDICAL REHABILITATION RESEARCH AND TRAINING CENTER (RT-19), THE UNIVERSITY OF ALABAMA IN BIRMINGHAM. (Grant #G008003058/NIHR).

RT-19 programs and projects were conducted within the physical facilities of the Spain Rehabilitation Center (SRC), which was established in 1964 on the Campus of the University of Alabama in Birmingham. SRC pro-

vides long term medical rehabilitation services to persons with physical impairments. Rehabilitation programs are offered to patients with spinal cord injury, cerebral vascular accident, head injury, amputation, multiple sclerosis, Parkinsonism, peripheral neuropathy, multiple trauma, rheumatoid arthritis, other collagen diseases and chronic pulmonary disease.

The final report contains background information on the center; organization and administration of the center; a research activity and training activity summary and the core areas of research activities that have been conducted over the years.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

REHABILITATION IN AUSTRALIA AND NEW ZEALAND: U.S. OBSERVATIONS. (Grant #G008103982/NIHR). Monograph Number Twenty-One, World Rehabilitation Fund/International Exchange of Information in Rehabilitation.

A compilation of fellowship reports by U.S. experts about rehabilitation in Australia. Reports included are: "Vocational Programs in Australia," Donn Brolin; "Innovative and Exemplary Programs in Australia," Richard Desmond; "Independent Living and Industrial Sheltered Employment," Altamont Dickerson; "A Look at Rehabilitation Engineering in Australia," Dudley S. Childress; "Developing Computerized Data Bases on Rehabilitation Equipment and Exchange of Information on Operation of Demonstration Units in the

United States and Australia," Marian G. Hall; "Rehabilitation of the Mentally Ill in Australia," Bertrum J. Black; "A Study and Analysis of Rehabilitation Laws, Rehabilitation Services, and Work-Return Strategies for Individuals Disabled by Industrial Accidents or Occupational Disabilities in New Zealand," Kenneth Mitchell; Home Modification for Spinal Cord Injured People: A New Zealand Overview," Sharon Wright.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

INTERNATIONAL YEAR OF DISABLED PERSONS. The story of the U.S. Council for IYDP. National Organization on Disability, 2100 Pennsylvania Avenue, N.W., Suite 232, Washington, D.C. 20037.

TOURS FOR PEOPLE WITH SPECIAL NEEDS. Israel for the disabled and elderly visitor. Palex Tours, 33 033 Haifa Israel, 59, Ha'atzmauth Road, 31 330 Haifa, POB 33018, Israel.

COMPUTER TECHNOLOGY FOR THE HANDICAPPED IN SPECIAL EDUCATION AND REHABILITATION: A RESOURCE GUIDE. Gary Nave, Philip Browning, and Jeri Carter. International Council for Computers in Education, 135 Education, University of Oregon, Eugene, OR 97403. \$7.

WOMEN AND REHABILITATION. Rehab Brief (Vol. VI, No. 1) National Institute of Handicapped Research, Office of Special Education and Rehabilitation Service, Department of Education, Washington, D.C. 20202.



Celluloid Images of Disability

Timothy Elliott

Television programs and feature films have long used characterizations of persons with disabilities. However, the nature and incidence of these portrayals is often demeaning and unrealistic. The TV movie *Battle Beyond the Stars* illustrates this contention. This particular program featured a villain who wanted to live forever and destroy the inhabitants of a peaceful colony on a neighboring planet. Described as a "ruthless conqueror" in a TV tabloid, this character maintained his existence by grafting body parts to replace his own timeworn appendages. Thankfully, the plans of this disfigured and malevolent militarist were thwarted by the end of the show. Another TV movie, *Fantasies*, implemented a more familiar depiction of disability. A mysterious assailant provided the dramatic plot by systematically murdering other characters in the film. No amount of strenuous detective work could produce any leads and one of the actors commented the murderer had to be a "madman." Surely enough, a mentally ill adolescent was revealed as the murderer in the conclusion.

Not all depictions of handicapping conditions are cast in such obviously derogatory roles. Luke Skywalker suffered the loss of a hand in a duel with Darth Vader in *The Empire Strikes Back*. But how many in the audience noticed the total absence of scars on his arm after a futuristic

technician replaced the hand? This noble Jedi knight exhibited no evidence of his prosthesis, in contrast to the visible disfigurement of the intergalactic menace described earlier. The primary character in the TV series *Ironside* proved that not all disabled people are evil; in fact they can be on the right side of the law. Notice that these characters are either very good and successful in spite of their impairment, or are very evil and readily distinguished by their disability. Both of these extremes fail to show the many dimensions and facets of a person with a disability.

Foundations of Stereotypic Depictions of Disability

The attempt to physically manifest some psychological and/or moral defect in a character is not novel. Whether consciously or unconsciously, screenwriters often resort to age-old stereotypes to define and create these portrayals of disabled people. Disability is frequently associated with evil, presumably on the literary premise that "visible defects give insight into moral defects" and the Judeo-Christian ethic that "physical defect is a just compensation for sin." At the opposite extreme, disability associated with goodness is grounded in the conception that "suffering and misfortune make a better person."^{1 2} A disability is then written into a story with the intention of

supplying the audience with a symbol or embodiment of psychological insight into the character. The attention of the audience is drawn to the disability, which spreads to engulf the whole person. This handicap influences the behavior of the character and saturates all facets of the character's life.³ If the character has evil inclinations, the underlying assumption is the person has suffered a vile misfortune as a consequence of some sin or misdeed, and the audience can anticipate similar behavior in the future. If the character is altruistic and chaste, the audience can assume the disability has presided as a purifying agent to teach the person of the true priorities in life. If the character has been impaired in one of the senses, most viewers would assume the person has naturally become proficient beyond normal capacities in another, to compensate the loss.

The tendency to portray disabled people within these stereotypic frameworks in media has a lengthy history. Depictions of disability in classical and modern literature have ingrained and perpetrated these misconceptions, and screenwriters have been well versed in the techniques of literary masters. Memorable among these characters is Melville's Captain Ahab, who had a peg leg and was depicted as being obsessed, scarred, and harsh. Shakespeare's murderous monarchs, Richard III and Macbeth, pos-

sessed handicapping conditions: the former was hunchbacked and the latter questioned his sanity throughout his treachery. Dr. Frankenstein's creature, Mr. Hyde, the Cyclops, Gollum, and the inhabitants of Dr. Moreau's island displayed some moral deficiency while personifying some type of monstrosity. Lawless pirates, including Captain Hook and Long John Silver, are marked by makeshift prosthetic devices and patched eyes. The god of fire, Vulcan, was talented as a blacksmith but was ridiculed by his peers at a banquet on Mount Olympus for his shriveled legs. The sophisticated Jake Barnes, maimed by war, was doomed to frustration. Lady Chatterly sought another when she could not stand the touch of her soulless, paraplegic husband. Oedipus was blinded for his sin against his family. The repulsive Rumpelstiltskin kidnapped children. The innocuous Pinocchio exemplifies to all children that facial disfigurement is preceded by disobedience and falsehood. Inversely, the characters of the hunchbacked Quasimodo and the disfigured Cyrano de Bergerac are notable because they are both deformed and good.⁴ And in a study of disabled characters in comic books, 57 percent of those with some form of disability were villains and 43 percent had hero status. None of the characters were neutral or in the background of a scene.⁵

Research Findings

From these roots, screenwriters typecast people with disabilities on film. Several studies have called attention to the nature of these depictions. Leonard⁶ reported that a significant amount of portrayals on television characterized disabled people as single, unemployed, and objects of ridicule, pity, and care. A sampling of the personality traits as-

cribed to these characters included dull, selfish, uncultured, defensive, and submissive. A substantial number were victimized by some physical or verbal abuse. Donaldson's⁷ research led to the conclusion that the visibility of disabled people on the television screen was disproportionate to the actual percentage of people with disabilities in the general population. Roles were generally major ones that focused on the disability rather than on the person. Disabled characters were exempt from incidental roles: In scenes involving crowds, bit parts, bystanders, and people casually strolling by to work or leisure, disabled people were conspicuously absent. Apparently disability is woven into a story only when it can be the focal point of the program; otherwise it just doesn't exist. Makas⁸ echoed these findings after an intensive evaluation of disabled characters on television. Rare was any portrayal of a person who just happened to be disabled, who just happened to be in the background, and the disability was not pieced into the story line. The majority of portrayals examined indicated that depictions of disability occur in television to concentrate on the disability, not the person.

Media leaders have defended themselves on the grounds that people want to be entertained, not informed, and they attempt to offer some avenue of escape using situations pertinent to present day concerns. Studies have supported this defense in part, observing the frequencies of disabilities portrayed. Drug addiction was quite popular on television in 1968, but it dropped substantially in 10 years.⁹ An extensive review of the literature insinuates that portrayals of disability in film thrive not to cater to public concern but to capitalize on public anxieties.¹⁰ Dramatic programs tend to carry more portrayals of disability,

entwining the characters in suspense and action.¹¹ Mental illness is portrayed more frequently than other disabilities; evidently it fits well into dramatizations requiring suspense and action to elicit audience anxiety.^{12 13} Although an actor may be realistic in the depiction of a specific disability, the general format of the program—be it dramatic or humorous—determines the impact of a portrayal on a viewer.¹⁴ Given the affinity television and movies have for depictions of mental illness, it is no wonder that Wall¹⁵ complained that these particular presentations emphasize "bizarre symptoms" and portray these people as "dangerous and menacing." He proposes that such distortions do abundant damage to the extent that viewers will hesitate to condone the operation of a psychiatric facility within their community. According to Livneh,¹⁶ disability is perceived as threatening when cast in these roles, and serves as a reminder of our own mortality and frailties.

Misinformation and Prejudice

Several articles discussing the possible effects of heavy and passive viewing of television programs on the behavior and beliefs of the audience have recently appeared in magazines like *Newsweek*, *U.S. News and World Report*, and *Reader's Digest*.^{17 18 19} They report that many viewers may be perceiving the images on television as being accurate accounts of everyday life. Television furnishes entertainment. Some people expect it also to relay a realistic narrative of our society. Contrary to the opinions of media leaders, people use television as a source of information to learn about their society and how to behave in certain situations. Attitudes are formed with the acquisition of information from depictions of disability on film. Subtle predispositions

which influence behavior are engendered by the misinformed, inaccurate, and stereotypic treatment of disability in movies and programs.²⁰ A viewer, after watching depictions described previously, may conclude that physical deformity is suggestive of an antisocial person, and a truly motivated and good person having an appointment with destiny will be able to overcome and erase any physical limitation. A viewer (or more appropriately, a coworker or employer) may suspect that a person with an impairment harbors a tragic past, a base impulse, or an undesirable lifestyle. The attitudes of the nondisabled viewer are preoccupied with confirming the negative, concealed, and morbid suspicions when encountering a person with an impairment. Any semblance of a similarity or positive interaction between the person with the disability and the nondisabled viewer is disregarded; the prejudice, fueled by the misinformation acquired through the numerous unrealistic portrayals in the media, seeks to gather evidence that would substantiate the belief, not refute it.

Perhaps these prevailing attitudes toward the disabled exist so strongly in the film media that any attempt to accurately depict a person with a disability would be perceived as fictitious, not factual. This would certainly explain why a film like *Bill* (an attempt to accurately present the account of a mentally retarded person's adjustment to work and independent life in a nonstereotypic fashion) was aired over the Christmas season. It's another fairy tale designed to cheer the holiday spirit, comfortably placed among the repeats of *Rudolf the Red-Nosed Reindeer* and *A Charlie Brown Christmas*. It's nice, but, within the seasonal context it may not be considered true-to-life. What does pass as plausible reality during regu-

lar programing is the story of a young mother prostituting herself to pay for the education of her disabled children, and how a Vietnam veteran, plagued with horrific flashbacks, takes hostages in a hold-up of a liquor store.

To summarize, studies have consistently argued that the images of disability in movies and television programs

- stigmatize disabled people by characterizing them as victimized objects, possessing undesirable personal qualities;

- give the illusion that disability is not a part of the mainstream of society; when it is present it is marked by some sort of stress, trauma, overcompensation, or character flaw;

- reinforce the negative societal attitudes toward the disabled by supplying viewers with a diet of inaccurate information concerning disabling conditions, which result in barriers to employment, communication, and other areas; and

- help maintain the stereotypic roles reserved in society for persons with disabilities, as they are reserved in the film media.

Guidelines for the Media

It is discomfoting to think that people may watch these depictions of disability without questioning, anticipating their future encounters with the disabled person on the street to mimic their experience with the disabled person on the screen. Characterizations of people with disabilities in the film media need to be sensitive to the realistic nature of these conditions. Some actors have tried to convey the multidimensional aspects of people with disabilities, including Jon Voight in the movie *Coming Home*. Prior to the shooting of the movie, Voight trained at the Los Ranchos Amigos Hospital and spent many

hours learning how people with spinal cord injuries occupy their leisure time and express themselves in a sexual relationship.²¹ The television series, *Tales of the Gold Monkey*, features Les Jankey, an actor who has a physical handicap, in a supporting role. The character is nonstereotypic in lifestyle and role, and the disability is secondary to the character and is not an intricate part of the program's episodes. Depictions such as these are especially refreshing, since they usher in the citizen with a disability as a bonafide member of the American scene, just passing by, standing in the background, participating in the affairs of day-to-day life. Presentations of this type portray people with disabilities as they really are: productive, active, and capable citizens who cope with their disabilities as they share the same everyday concerns and responsibilities of their fellow citizens.

In 1982 a United Nations seminar on media and disability constructed guidelines to assist networks and producers in their characterizations of people with disabilities. Many international professionals participated in the development of guidelines which could apply to all forms of mass media. A booklet on the guidelines is in production and will eventually be available to the public. The guidelines, presented below, have the primary objective "... to present people with disabilities in ways that, wherever possible, demonstrate their varied, positive, and multidimensional participation in society".²²

1. Depict people with disabilities at home, at work, at school, at leisure, and in a variety of other ordinary social and physical situations.

2. Acknowledge the natural curiosity and occasional awkwardness that may develop in social situations involving disabled and nondisabled individuals. Where appropriate, provide

positive examples in which such curiosity is satisfied and in which awkwardness is lessened.

3. Include people with disabilities as part of the general population in media products in addition to those in which their story is the primary focus.

4. Avoid presenting people with disabilities as dependent or pitiful. Other stereotypes to be avoided include presenting people with disabilities as inherently saintly or asexual, gratuitously dangerous or uniquely endowed with a special skill due to a disability.

5. Consider carefully the words used to describe or characterize disabled people. Recognize and avoid phrases that may demean these people (e.g., blind as a bat, deaf and dumb).

6. Portray people with disabilities in the same multidimensional fashion as others.

7. Present the achievements and difficulties of people with disabilities in ways that do not overemphasize the impairment or exaggerate or emotionalize the situation. For example, in news stories and documentary reports, the fact of a person's disability should be reported only when it is directly relevant.

8. Information should be provided to the public about prevention of and treatment of impairments that lead to disability, as well as the availability of services for people with disabilities and their families. This can be done through public information campaigns and also can be integrated into general media products.

Hopefully these guidelines can assist the incorporation of realistic depictions of people with disabilities into movies and television programs. Accurate portrayals would promote positive interactions between those with handicaps and members of the vigilant audience of the film media.

Interactions of this type are crucial to the formulation of realistic attitudes toward the disabled. If misaligned depictions of disability are deliberately portrayed to reflect society and are passively accepted as such, subtle negative preoccupations will continue to erect barriers that can hamper the lives of many citizens.

Timothy Elliott has an M.S. in Rehabilitation Counseling from Auburn University. He is a doctoral student in Counseling Psychology, University of Missouri-Columbia. The author extends appreciation to Ken Lass for his assistance in the preparation of this paper.

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NEWS, NOTES, ANNOUNCEMENTS

Lighthouse Trainees Competitive In Automated Area

Lighthouse clients, trained on up-to-date word processing equipment in the Clerical Skills Training Center, are winning jobs in competition with sighted applicants because of their word processing experience.

Laura Hughes, after training for just 3½ months on the new Xerox 860 Informational Processing System, successfully competed against 13 fully sighted candidates for a job with a technical book publisher. Laura, who holds a bachelor's degree in criminal justice, chose training in word processing as a way of getting into the job market. She plans to go on to graduate school as well.

Another clerical skills graduate, Annamaria Bloom, came back recently on a part-time basis for training on the IBM Mag II. She is an employee of Manufacturers Hanover Trust, which has given her time off to upgrade her skills under the sponsorship of the State Commission for the Blind and Visually Handicapped. A clerk typist/receptionist, Annamaria wanted the additional skills both to do a better job and to continue to keep up with sighted coworkers.

The Xerox 860 represents the most modern equipment available. It has a visual screen which can show the text being typed in black on white or white on black and can enlarge the print up to bulletin size without the use of supplementary adaptive devices.

According to Nadine Saxton, senior clerical instructor, Lighthouse stu-

dents, using their word processing knowledge along with other skills learned in the clerical skills program, can adapt to any word processor an employer may have.

Word processing can be learned by totally blind students as well as those with some vision like Laura and Annamaria. In fact, The Lighthouse plans to add voice output technology which will enable blind students to correct their own errors and will pave the way to teaching computer programing.

Technology of this sort "will provide virtual equality to blind and visually impaired people," says Dr. Lawrence Scadden, president of Rehabilitative Technology, Inc., who spoke at the Women's Committee Annual Meeting in May.

Lighthouse News, The New York Association For The Blind.

Corporation-Employee Match Made Before Computer Training

Lift, Inc., a not-for-profit corporation, trains and hires severely physically disabled men and women for computer programing. The company was founded in October 1975 in Chicago and operates there and in New York, Los Angeles, Phoenix, Denver, and Boston where it has served over 50 major corporations and computer programers.

People who are highly intellectually qualified and motivated are prime candidates for this program. Severe physical disabilities need not be barri-

ers in the computer programing field. Typical disabilities of some of Lift's employees are quadraplegia as a result of spinal cord injury, cerebral palsy, muscular dystrophy, and polio.

After candidates are identified, Lift matches them with a corporate client before training begins, so that the format of the training program may be tailored to employment needs, and so that trainees can establish a rapport with their future clients and employers at an early stage. Lift provides education in the trainees' homes by use of a 6-month audiovisual course, remote computer terminals, and tutoring, and then hires the programers to work for Lift. Due to the nature of their disability, they are usually unable to work in a conventional office environment and commute on a daily basis, so this in-home concept matches their unique needs and enables them to do much of their work at home. They are, however, encouraged to enter the workplace by use of a van, a car with hand controls, and/or an attendant, if required, to maintain a quality relationship with their employer and peers.

When the training program has been completed successfully, each programer is hired by Lift and assigned to full-time projects with his or her corporate client. After a year of contract employment, programers should be hired directly by their major corporate clients.

With the assistance of Lift, bright, motivated, disabled adults are able to pursue suitable careers, earn competitive salaries, and take advantage of full scale medical benefits. More importantly, they are able to live more independent, self sufficient lives, while corporations are able to use the benefits of bright, committed, and competent employees.

If you or anyone you know qualify for this program, please write to the

following address and include a summary of both your educational and personal background: Lift, Inc., Attention: Leslie Woerner, 4 Ayr Road Apt. 41, Brighton, MA. 02135.

Together, Information Center For Individuals With Disabilities, Boston.

Technical Signs Available From NTID

The invention of manual sign language did a great deal to facilitate communication for people who are deaf. However, with the progress of technology, new words were invented for which there were no signs. While these words can be fingerspelled, they are often long and complex which leads to a slowing down of the visual communicative process.

Now that barriers against education and employment of people who are deaf are beginning to break down, the problem of communicating technical language has assumed greater importance. In response to this need, the National Technical Institute for the Deaf at Rochester (New York) Institute of Technology conducted a nationwide research project called the Technical Signs Project, to collect and establish a nationally based system for sharing signs used in academic and career environments.

These specialized signs have now been collected in 22 videotapes and 5 manuals. Over 1,500 signs are illustrated on the tapes, which cover 17 topics. All the tapes are available for free loan or sale.

Details on availability of tapes and manuals and subject areas covered are available from Special Materials project, 624 E. Walnut Street, Indianapolis, IN 46204, or by calling Frank

Caccamise, Ph.D., at (716) 475-6420.

Rehab Review, California Department of Rehabilitation.

Four Publications Available Through Resource Center

The HEATH (Higher Education and the Handicapped) Resource Center, a project funded by the U.S. Department of Education, has produced three fact sheets and a packet on careers in working with handicapped people. The HEATH Resource Center is a national clearinghouse on postsecondary education for disabled people.

Cost Effective Ideas for Serving Disabled Students on Campus was prepared for trustees, administrators, and other planners in the higher education community. It identifies long range planning strategies, suggests specific questions to ask prior to initiating a program or purchasing equipment, pinpoints a number of cost effective ideas now in use on American campuses, and includes an annotated resource list.

Education for Employment is a guide to postsecondary vocational education for students with disabilities. Vocational education is described within the historical and legislative perspectives and then focuses on how the components of a vocational education program can be adapted to include disabled students. Examples from a variety of postsecondary programs illustrate how assessment, curriculum modifications, devices and technology, testing, and job development have been made accessible to students with disabilities. Recommendations are included for adminis-

trators, instructors, support staff, and students.

Vocational Rehabilitation Services, A Postsecondary Student Consumer's Guide provides an overview of both the system and the process of accessing it. A State Agency List is included to help in locating a vocational rehabilitation office.

Careers Working with Handicapped People is a packet of information containing the HEATH brochure, an article by the Clearinghouse on the Handicapped titled "Careers in Helping the Handicapped," the Student's Guide to Five Federal Financial Aid Programs, and a list of other financial resources for students.

These materials are available without charge from: HEATH Resource Center, One Dupont Circle, N.W., Washington, DC 20036, (202) 833-4707 (Voice or TDD).

Wheelchair Allows Effortless Standing

A new wheelchair is now on the market that allows its user to stand with no effort at any time. Called the LEVO, the chair is precision made in Switzerland and is designed to be size adjustable, which makes it suitable for young people who are still growing. It is lightweight and can be folded away for easy storage or transport. The LEVO can be used either manually or with an optional power pack which converts it to an electric wheelchair.

Information on the LEVO Lightweight Stand Up Wheelchair is available from R & N Wheelchair Co., Star Route 2, Box 1249, 21525 Quail Springs Road, Tehachapi, CA. 93561; Telephone: (805) 822-5623.

Independent Living— Cost-Effective In Maine

Denise Richard

The maxim, "The only constant is change," is a truth which is clearly evident in these turbulent years. Rapid advances in science and medicine have dramatically altered old relationships between life and death, health and sickness, ability and disability. In the span of only a few decades these relationships have been redrawn. As a result, people now live longer lives, healthier lives, and more active lives. And people with disabilities, particularly people with severe functional impairments, have benefited tremendously from the progress of the last 30 years. Applied science, biomedical engineering, and medical research have made possible opportunities for persons with severe disabilities that simply did not exist in the past. While only the visionary can imagine what wonderful new discoveries will be made in the future, one can safely assume, the years to come hold even greater opportunity for disabled persons.

As people with severe disabilities gain new opportunities to participate in the community, they gain a new awareness of their abilities. In time this growing confidence in their abilities has led people with severe disabilities to exercise greater control of their lives and their destinies. This exercise of natural ability, aided by

new technology, has become known at the grass-roots level as "independent living." A concept with so many applications as independent living is difficult to define in a few declarative sentences, but in every instance independent living does exhibit certain common characteristics.

Independent living springs from the abilities of a person with a severe functional impairment. In essence, independent living is a positive approach to difficult situations which depend upon the energy and commitment of disabled people themselves. Independent living is doing for oneself. This does not necessarily mean actually performing a task oneself, but rather it means being responsible for a task being done. Little does it matter whether a machine, an aide, or someone actually performs the work. Seeing that the task is done and done properly is what is most important. *The responsibility of an individual for himself or herself, self-responsibility, is a primary characteristic of independent living.*

The lower costs of independent living are not illusory. It is no mystery how independent living can deliver quality care more satisfactorily at a fraction of the cost. There are two primary reasons—lower overhead and less staffing. Capital costs and per-

sonnel costs are the biggest part of any business, and human services are no exception. But independent living, by its very nature, seeks to minimize these costs. On the one hand, independent living's goal is the least restrictive, least institutionalized setting. Institutions are capital-intensive. The construction costs of new hospitals and nursing homes are skyrocketing and the burden of past, present, and future construction is reflected inevitably in higher costs. Independent living seeks to place persons singly or in groups in existing community housing. And on the other hand, more restrictive settings assume the responsibility to care for the individual, whereas independent living seeks to enable individuals to assume that responsibility themselves. Quite simply, government can pay for persons with severe functional impairments to be taken care of or government can make it possible for those same persons to care for themselves. The choice is there. The option of independent living exists today, and with planning an ideal network could be functioning statewide (in Maine), disability-wide by the mid-80's.

Before setting forth the data, several other explanations for the cost-effectiveness of independent living should be made. One explanation is

that independent living is essentially preventive. One goal of an independent living network is to anticipate and move to prevent institutionalization. Whether it is an infant with Down's syndrome, an adult with cerebral palsy, or a citizen with diabetic vision loss, an independent living network can teach the skills and provide the support which will add years in the community. Each year in which institutionalization is not required is a year of saving; a lifetime without institutionalization is a lifetime of saving.

Independent living is not limited to persons with certain disabilities. Although the method and even the form of independent living may differ from disability to disability, there is the opportunity for more responsibility and greater freedom within every disability. Many methods and much equipment can be interchanged or adapted to meet the needs of persons with different disabilities. In the design of services especially, the lessons of one disability are useful to another. But even within the same disability there are persons with varying degrees of ability, and independent living should be a goal for everyone. Independent living does not mean living without assistance. Persons with severe functional impairments will always need assistance. It does mean a higher accomplishment, increased control, and greater dignity. *Accomplishment, therefore, is another common characteristic of independent living.*

The substance of this accomplishment and responsibility is basic life management. The activities of daily living are the grist of the independent living mill. For the most part, persons with severe disabilities have led sheltered lives and have not shared the experiences of living in the community. The knowledge, skill, and confi-

dence that grows from these experiences have been denied persons with severe disabilities. It is not social ability which persons with severe disabilities lack, but rather social training. To live independently, persons with severe disabilities need to be taught the basic skills of daily living. The process of preparing a person for independent living is an educational process, and skills training is at the heart of every effective independent living program. *Learning is the third characteristic of independent living.*

Cost Effectiveness

In a time of increasing budgetary pressures, it is especially important that programs be cost-effective. While there are many good reasons to support the development in Maine of an independent living network, one of the very best reasons is the cost-effectiveness of independent living services.

Another factor which adds to the cost-effectiveness of independent living is the accuracy of services. An individual with the responsibility for his own welfare is disposed to seek only the care and only as much of that care as he needs. This accuracy means unnecessary care is avoided.

Services in institutions are too often provided because the capability to provide them exists and consequently services too often are delivered unnecessarily.

Efforts have been made on the national level to reflect actual cost saving averages. While it is possible to report these averages, we feel it would be unfair and inaccurate. Just as national averages for the number of disabled individuals do not accurately reflect the picture of Maine's disabled population, neither do the average cost saving figures. Maine's uniqueness in geography and service availability preclude any national averages. Accurate cost saving figures must be generated from actual service provision, followup, and Maine's own survey of its disabled population.

The following tables reflect the type of data that would be collected by Maine Independent Living Center (MILC) and reported to the Legislature.

Table I is a table of average (estimates are starred*) of the cost per setting. Estimates were used for supervised and the two unsupervised settings since the cost is totally dependent on the individual. The esti-

Table I
Cost of Care Setting per Person per Year*
*average

Setting	Amount
Pineland Center	\$42,142.00
Mental Health Institute	39,700.00
Skilled Nursing Facility	21,900.00
Intermediate Care Facility—Nursing	15,695.00
Intermediate Care Facility—MR Group Home	27,100.00
Private Boarding Home	5,750.00
*Supervised Apartment	2,600.00
*Unsupervised Apt. w/Home Health Agency	780.00
*Unsupervised Apt. w/Personal Care Attendant, Homemaker, Companion	3,822.00

mates are based on the following: Supervised apartment, 25 hours per week at \$5/hr.; Unsupervised with Home Health, at \$15/week; Unsupervised with PCA, Homemaker, Companion, 21 hours/week at \$3.50/hour.

Case Histories

The following actual examples of the current independent living network are intended to illustrate the potential of the network in human as well as financial terms. These examples have been chosen to prove that independent living is not just a theory, but that it has worked. While not every individual receiving services has been as successful as these examples, on the basis of the cohort that have been through the entire program, independent living is a choice for persons with severe functional impairments which more than pays for itself.

“A” is C-3 spinal cord injured quadriplegic in her early 20’s. Ms “A” was previously in a nursing home at a cost of \$33,905 annually. In March of 1981 Ms “A” started a 1-year program in independent living at Alpha I. The cost for this service was \$35,666. Following training, Ms “A” moved into her own apartment and continued school (under vocational rehabilitation). The cost, \$26,882/annually. When Ms “A” finishes school it can be projected that costs will be limited to personal care assistance which will enable her to work (and subsequently pay taxes). Cost for personal care \$11,604.

Cost Breakdown/year

Nursing Home

\$33,905

Alpha I

\$35,366

Own Apartment

*(while in school)

\$26,882

Projected Own Apartment

*(school completed)

\$11,604

“B” is a Bi-lateral Hemi quadriplegic (a result of a head injury) in his late 20’s. Mr. “B” was previously in a nursing home at a cost of \$17,431/annually. In March of 1982 “B” completed the 1-year Alpha I independent living program at a cost of \$18,082. “B”, who is now attending college through vocational rehabilitation, lives in his own apartment at an annual cost of \$16,355. It can be projected that “B” will require only personal care assistance, following the completion of his education, at a cost of \$3,672/annually.

*Cost Breakdown/year**

Nursing Home

\$17,431

Alpha I

\$18,082

Own Apartment

*(while in school)

\$16,355

Projected Own Apartment

*(school completed)

\$3,672

Mr. “C”: This 22 year old male, legally blind from glaucoma and cataracts, had a history of environmental deprivation as a child and was still living with his parents. He had no employment goals prior to receipt of blind rehabilitation community services. He entered a group home for the developmentally disabled which resulted in his adopting various personality characteristics of his group home peers. The rehabilitation team, con-

sisting of the personal adjustment counselor, social worker, and rehabilitation teacher addressed self concept development, basic activities of daily living skills acquisition, sensory development, personal hygiene, and related skills. During this rehabilitative process, he desired to increase his independence and requested enrollment in the MCB Residential Training Program where training in the above listed skills continued on a more intensive level. He is now employed full time, a Member of the Board of an organization for the handicapped, travels independently and safely throughout the Portland area, is able to provide for personal needs and, in essence, no longer dependent upon society. He is actively pursuing a career in woodworking at this time.

Cost Breakdown/year

Group Home

\$27,100

MCB

\$4,126

Own Apartment

-0-

Mrs. “D”: Is a 77 year old widow, legally blind from macular degeneration, also afflicted with coronary heart disease and severe arthritis. Her inability to manage her financial affairs resulted in her being subjected to repeated, short term places of residence. She had to rely continually upon others for meal preparation, basic hygiene, shopping, cleaning, etc. She was rapidly becoming a burden to her neighbors who had to respond to her repeated calls. When the rehabilitation teacher responded to the referral, preparations were being made for a nursing home placement. The rehabilitation teacher began basic instruction in meal preparation, stove safety,

training in the use of prescribed low vision aids, financial management instruction, personal hygiene, and related skills. The personal adjustment counselor began counseling her on a regular basis to assist her with her adjustment to blindness. At this time, she is preparing to move into a low income housing project and is able to maintain a high degree of independence with a minimal amount of support.

Cost Breakdown/year

*At Risk of
Institutionalization*

MCB

\$2,593

*Own Apartment
(Rent Subsidy)*

\$2,041

Mr. "E": This 24 year old male, who is physically handicapped as well as mentally ill, was served by Middle Street House for 6½ months. Prior to being admitted to the group home, he had spent 14 months in Bangor Mental Health Institute. He was hospitalized because of his aggressive behavior toward family members and a number of suicidal gestures. Because of his physical disability and the dynamics of his family, this young man had not had the opportunity to develop the functional or vocational skills necessary for leading an independent life. When he applied to Middle Street House, he described himself as needing "help . . . to communicate with people and help . . . being more independent."

Middle Street House provided a transitional setting for this young man. When he left the hospital, he had neither the emotional resources nor the functional knowledge necessary to live independently. Neither

the client nor the professionals working with him felt he would benefit by a return to his family. The group home provided this client with a variety of supportive group experiences, ranging from formal group therapy where he learned to identify and work on his problems with communication, to instructional groups that dealt with budgeting and cooking. He also moved through a continuum of vocational settings beginning with volunteer work as a cook at the LINC Social Club and culminating in a paid training position at the A.M.H.I. Canteen. Through his vocational placements, he developed an interest in pursuing cooking as a career and applied and was accepted in a 9-month food preparation program in his home town. After leaving Middle Street House, he entered this vocational school and is currently doing well.

Cost Breakdown/year

Bangor MHI

\$37,600

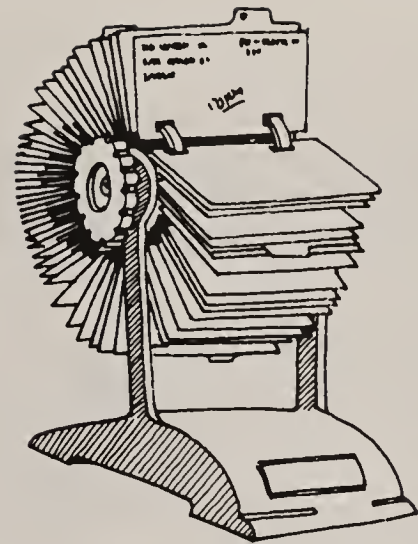
*Middle St. House
(6½ months)*

\$5,858

Own

Tuition

"F" is a 31 year old woman who became a ward of the state at age five. She is now diagnosed as having an intermittent explosive disorder and borderline mental retardation. She has had a long history of institutionalization (Pineland 1964-1973 and A.M.H.I. 1975-1982). She has had difficulty dealing with stress, and her lack of emotional control has been a main factor in her need for hospitalization. Recently "F" has made a great deal of progress in learning emotional control, chiefly through her



participation in structured learning therapy classes at A.M.H.I. She has also benefited greatly from A.M.H.I. classes in making change, cooking, personal hygiene, etc.

"F" entered the program in October 1981. At that time, she was a patient at A.M.H.I. Initially, the LINC Program began working with her to provide her with support, as the client began making plans to leave the hospital and move to an apartment in the community. Eventually, when "F" felt comfortable with the idea of leaving the hospital, she and the LINC staff began actively seeking an apartment in Augusta. A suitable apartment was found in February 1982. The program assisted "F" in moving to her new apartment by providing for a staff person (helped by two client volunteers) to transport all her belongings to her new apartment. Shortly thereafter, LINC referred "F" to the Diocesan Human Relations Services for homemaker services (mostly assistance with finances, shopping, and laundry). LINC also arranged for three loans, totaling \$440 to "F" which made it possible for her to pay rent and security deposit. She repaid these when she began receiving SSI payments. Since she moved to her apartment, a LINC staff person has met with her weekly to monitor her

situation. She has been maintaining herself in her apartment. She does well at housekeeping, and has decorated her apartment quite attractively. She continues to attend classes at A.M.H.I., including various classes at the Marquardt School, as well as SLT classes. "F" seems to be developing a somewhat better socialization ability, but still prefers to spend a great deal of time in her apartment watching television.

Cost Breakdown/year

AMHI
\$39,700
LINC
\$1,275
OWN
?

"G" is a 30 year old mentally retarded woman who lived at Pineland Center until 8 years ago. At age 22, she moved into a boarding home where she was sheltered and exhibited no independent living skills for 2 years. In 1977, she went into an ICF-MR setting, and subsequently into a home where skills training in life management was being taught. After finalizing the program, she moved into a supervised setting with a friend and is currently living on her own with minimum support. She is employed, reliable, and doing extremely well.

Cost Breakdown/year

Pineland Center
\$42,142
ICF-MR
\$27,000
Own w/Support
\$3,600

"H" is a Down's Syndrome man of 34 who spent his childhood both at home and at Pineland Center. Following a brief period of time on his own, he entered a group home. He graduated from the developmental skills training program in December of 1981, and is living in a minimally supervised apartment. Mr. "H" works daily and projections are that he will be competitively employed in the near future.

Cost Breakdown/year

Pineland Center
\$42,142
Group Home
\$29,200
Own Apartment
\$3,600

The above case histories, as previously explained, were selected because they clearly show that independent living for severely disabled people is not only possible but practical and even more, necessary to the dignity of the individuals involved. The figures reflected in the histories were not scientifically gathered and represent average costs rather than accurate reflections of individual client costs.

The histories are excerpted from *Independent Living: A Prospectus For Maine*. The report, prepared by the Maine Independent Living Center, was submitted to the Maine Legislature in conjunction with Maine's first I.L. legislation which was signed into law by Governor Joseph Brennan on June 30, 1983. Single copies of the summary report are available from the Maine Independent Living Center.

Ms. Richard has worked in the social services field for the last 12 years and is currently Executive Director, Maine Independent Living Center, Augusta.

TOPIC OF STATE

(Continued from page 6.)

classroom atmosphere is that of a business college—pleasant and modern.

Job entry is of major importance to CORC. "Our facility goal is 80 percent placement," Cunningham explained. "All our students also receive job seeking skills training which includes resume writing, interviewing techniques, videotaped interviews (including playbacks) with business professionals, and enrollment in our job club. We work with everyone until placement."

Most of the current enrollees have not previously held significant jobs, but upon completion of the CORC course, they should be able to start at \$800-\$900 per month. The center will permit students to work in its own offices to gain actual job experience, and Cunningham said there may be some internships established.

It is hoped that during the next year, 25 of the 60 disabled persons who begin CORC's business office skills training program will go on to be enrolled specifically in the word processing curriculum. Referrals from outside the Columbus area can be accepted, but these individuals must make their own living arrangements.

Word processing programs similar to the one at CORC have also been established via federal funds through RSC establishment grants at Toledo Goodwill Industries and Vocational Guidance and Rehabilitation Services in Cleveland.

Accretiveness—

A Concept Of Independent Living

Glenn S. Leavitt

People have characteristics, and so do programs. We at the Michigan Commission for the Blind, Centers for Independent Living (CIL), found that one of the very positive characteristics of independent living rehabilitation was awkward to describe. Our CIL's were not only humane and cost effective, but the community was getting more out of the programs than we were putting into them.

After a little digging, we found an English word that very accurately describes the characteristic we have in mind: *Accretiveness*. An accretive endeavor so attracts resources that the total of its output exceeds the planned and budgeted input. For instance, our centers planned and budgeted for the salaries of its six employees whose yearly work output could not reasonably be expected to exceed 2,000 hours each, or 12,000 hours per year for the 6 of us. However, independent living rehabilitation is such an attractive concept for both consumers and communities, that the number of work hours expended substantially exceeds 12,000.

Where do these additional hours come from? They come from community volunteers, service clubs, partici-

pants' families, and program participants themselves.

Examples of CIL Program Accretiveness in Terms of Hours:

1. A group of Lions Club members spent a Saturday putting on a new roof, so a CIL participant could remain in her home and avoid institutionalization.

2. Another Lions Club group contributed a day's labor to move a frail, elderly, CIL participant to a first floor apartment where she could continue to live independently.

3. Two homebound CIL participants each contribute 8 hours a month as telephone peer counselors for other program participants.

4. University students in recreational therapy, art therapy, and special education, have spent a semester with the CIL program working with CIL participants in their homes.

A volunteer word processor operator has contributed 50 hours preparing CIL materials for distribution in print and braille.

6. A RSVP volunteer contributes 8 hours a week helping in the CIL office.

7. Another volunteer visits one participant 3 hours per week to read mail and help organize household affairs, and drops in on another to administer eye drops for glaucoma.

8. An Optometrist, specializing in low vision aids, sold us aids for a participant at costs, and then donated 4 hours of her time to train the participant in using the aids.

Examples of Accretiveness in terms of Dollars:

1. Various Lions Clubs around the state have contributed: \$900 for a new roof to keep a participant's home liveable; \$292 for a back yard fence, so a blind mother could keep track of her small children; \$400 toward the total cost of a participant's eye surgery; \$400 for a participant's pre-

scribed low vision aids; and the list goes on . . .

2. CIL participants purchase equipment and materials needed for the completing of their ILR, ranging from a few dollars worth of craft supplies to \$2,000 closed circuit TV magnifiers.

3. National Federation of the Blind (Lansing Chapter) contributed \$120 to help the CIL consumer group leaders meet the expenses involved in getting the group together.

Examples of Accretiveness in Terms of Community Service. As a result of successful independent living rehabilitation, individual CIL program participants have contributed to their community by: Taking a leadership role in the development of transportation for elderly and handicapped in a predominantly rural country; becoming an aid at a local school; continuing to run a used car business at age 84; leading a church performance of the Messiah; knitting woolens for distribution to the poor; becoming a volunteer helper at a day care center; and CIL program participants have organized into a self supporting, self perpetuating group devoted to the continuation and expansion of ILR for the blind in Michigan.

Certainly, most IL programs could add many dramatic examples to these lists. So, we suggest that the term *Accretiveness* be added to your arsenal when you are called upon to describe the positive characteristics of ILR programs. ILR is not only humane and cost effective, its value is greatly enhanced by the *Accretive* nature of this kind of human endeavor.

Mr. Leavitt is a supervisor in the Michigan Commission for the Blind, Centers for Independent Living, serving the elderly and multiply severely disabled blind in 26 counties of the state.

Barriers To Blind Progress

Eunice Fiorito and Jim Doherty

We who cannot see do not look on blindness as the "affliction" it is often termed. It does create problems; it is frequently a nuisance; and no one can deny that it sometimes limits our options. But for us, the most devastating effect of blindness occurs in the minds of the nonblind people with whom we come in contact. A recent episode is a case in point.

A blind couple we know went out shopping. As they walked toward a nearby center, they encountered a woman going in the opposite direction. She apparently saw only a white cane and a dog guide; for, as she passed, she clucked her tongue and audibly remarked, "Isn't that too bad." The couple's obvious confidence and cheerful demeanor meant nothing to this woman. They ignored her. The shop they sought was in a far corner of the center, across a wide open mall, factors which could make it difficult to locate a specific doorway. Therefore, they walked to the general vicinity of the store and asked a passerby if he could help them. Perhaps flustered at being asked for directions by two people who couldn't see him, the man just pointed, said "over there," and hastily departed.

Undaunted, our friends entered the nearest establishment and received the proper information from a helpful cashier. Then, as they approached their desired destination, a wine and cheese shop, someone said to a companion, "Why are they going in there? Blind people shouldn't be allowed to drink liquor. They have enough problems getting around already."

This story points up several attitudes which, while merely annoying in this set of circumstances, become formidable barriers when we apply for jobs, seek advanced education, attempt to widen our social contacts and in other similarly serious life situations. The groundless doubts and misconceptions reflected in these attitudes often lead to irrelevant, personal questions that would never be put to a person with normal sight: How do you shave? Who picks out your clothes? How do you get around? Who takes care of you? Do you ever try to cook? Are you able to work somewhere? When this happens, most of us try to be polite and conversational, and, occasionally, we wind up with a new acquaintance who realizes the inanity of such questions. But

we're only human and must be forgiven if we are not always so gentle.

Age-old fears and the human need to feel superior are the basis of the discrimination and lack of understanding blind people are subjected to. In biblical times, a blind person was thought to be possessed by evil spirits and, therefore, a source of terror and disgust. Even as late as 1980, a survey found that blindness is second only to cancer on the list of conditions people fear contracting. Through the centuries, the word "blind" has been given connotations that have no relationship to the condition it describes. We have "blind ambition," "blind alley," "blind date," etc. Against this background of myth and metaphor, it is hard to convince people that the only thing a blind person cannot do is *see*, that "blind" means only the physical inability to see, and that the limitations range from total blindness to a good measure of useful vision.

Of course, we face obstacles. Information gathering is more difficult for us because most things we want to read are printed or handwritten in ink, not braille. Since we depend so much

on sound, our mobility and orientation can be disrupted by excessive noise. But everyone faces obstacles of some kind: Short people can't reach top shelves. Those who are very tall or extremely overweight have trouble finding clothes and furniture that fit comfortably. All such obstacles, however, can be overcome with ingenuity and sometimes a little help from our friends.

Most people think that any problem we have is compounded by blindness, but this is not necessarily true. However, obtaining help, particularly the reaction to a request for help, is always affected by our blindness. For example, when a nondisabled person asks for assistance, it is understood that the need is only momentary. But when a blind person asks for assistance, it is automatically assumed that he or she is totally helpless. The false logic goes: If you can't find the right office the first time you visit the company, how could you ever program a computer. Such a ridiculous generalization would never be applied to someone with normal sight.

Again, it is tradition that equates blindness with helplessness. And the extension of that equation says: If you can pity people who are blind, you needn't try to understand them. That absence of understanding is a tremendous source of irritation for us. It forces us into countless uncomfortable situations. A bus driver makes a passenger give up his seat because he knows a blind person is incapable of standing during the ride. A teacher will look on, tearfully amazed, as a blind student types. A blind woman is complimented, not because her dress is pretty, but because she coordinates colors so well—even though she can't see them. The unnecessary concern, amazement, and wrong-headed praise are simply other manifestations of pity and just as disturbing.

An entire industry has grown up around the traditional view of blindness. Organizations and government agencies *for* the blind have been established throughout the world. Several poetically refer to themselves as "lighthouses." Incidentally, some of us have suggested extending the poetry to other disability groups, with "The Foghorn for the Deaf" and "The Ladder for the Quadriplegic." While a number of agencies and organizations have rendered invaluable service to blind people, others seem to be in business to perpetuate our dependence and use it as a tool for fund raising. We have been used in this manner for decades. The situation began to improve only when blind people organized for concerted action.

The organized blind movement has been the key to our progress. Working together, we have brought about more effective services, better and more realistic education and training for blind children and adults, and supportive legislation to guarantee the permanence of these advances. Another of our goals is broader and more informative contact with the nonblind world. In the United States, 4 million people are classified as "visually impaired," a term that covers the range of visual acuity from total blindness to 20/200. We look forward to the day when these 4 million citizens will no longer be isolated in a special population group, when we can fully participate in the social, economic, and political life of our nation.

Technology is bringing that day closer. Computers that print and store braille and even speak are eliminating information barriers. Portable reading machines are opening new vistas of personal and business communication. Technology is important primarily because it makes us more employable. For anyone who has lived on public assistance and tax supported

services, the possibility of earning and spending money—and even paying taxes—is the key to personhood; for economic independence promotes confidence and self esteem, and the combination can lead to greater social acceptance.

Gainful, productive employment, however, does not free a blind worker from discrimination. When legally required affirmative action opens opportunities and technical advances make more jobs manageable, discrimination becomes more subtle. Insensitive superiors steeped in traditional beliefs continue to deny assignments, ignore suggestions, and pass over blind employees for promotion. One answer is civil rights legislation for disabled persons, and that is being pursued. But permanent improvement will not come until the subtle discriminators recognize and accept us as equals.

This presentation seeks to encourage the reader to think in terms of equality. Regardless of such variables as education, cultural background, age, sex, or physical dimensions, each of you certainly considers herself or himself the equal of all other human beings. Every blind person is also a unique individual, living—as you are—according to his or her abilities, needs, experiences and heritage, and, therefore, no more or less worthy of the care and concern of our common Creator and all fellow creatures.

Ms. Fiorito is Acting Special Assistant to the Associate Commissioner, RSA. Mr. Doherty is a freelance writer and was previously a writer for the Community Services Administration. This paper was presented at the 80th Annual Convention Religious Education Congress and Exposition, National Catholic Educational Association.

Functional Electrical Stimulation In Managing Neuromuscular And Musculoskeletal Problems

Emily Gromar

(Among the world leaders in research on functional electrical stimulation is the Rehabilitation Engineering Center in Ljubljana, Yugoslavia, which is partially supported by the National Institute of Handicapped Research. Collaborating with this center are the Rehabilitation Institute Ljubljana, the University "Edvard Karelj" Ljubljana, the Jozef Stefan Institute, the University Urological Clinic, and the University Clinic for Gynaecology and Obstetrics. Much of the information in this article is from the Rehabilitation Engineering Center's final report.)

Functional electrical stimulation (FES) of paralyzed muscles has proven to be an effective method for correcting locomotion in stroke patients. At present, functional electrical stimulation is also being introduced into the rehabilitation of spinal cord injured patients with upper motor lesions. It is used to strengthen unused atrophied muscles of complete and incomplete paraplegics and quadriplegics; prevent further muscle atrophy; provide better blood flow in the stimulated extremities and thus prevent pressure sores; prevent contractures; and retrain paralyzed muscles to per-

form functional movements.

A two channel stimulator has been developed that enables standing in complete paraplegic patients. More than an hour of secure standing has been achieved by locking the knee joints by electrical stimulation of both knee extensors. By stimulating the hip, knee extensors, and ankle plantar flexors of both lower limbs, a paraplegic patient is able to rise from a sitting to a standing position with the aid of arm supports.¹

A four channel stimulator is being used to restore biped walking in complete paraplegic patients. The simple gait pattern is divided into the double stance phase and the swing phase. During the double stance phase, extensor muscle groups in both knees are stimulated to provide sufficient body support. The swing phase is accomplished through excitation of the flexion synergistic response. By stimulating above an afferent nerve of the leg, flexion of the hip and knee together with ankle dorsiflexion is obtained. Patients have been able to walk with the help of the stimulator and a commercially available walker or crutches. The two stimulation switches, which provide the transition from the double stance phase to the swing phase, are placed in the han-

dles of the walker or crutches.²

FES Principles

The term functional electrical stimulation describes the external control of nondenervated but paralyzed muscles by electrical stimulation of the corresponding intact peripheral nerves and muscles to achieve functional movements. The excitability (contractile response) of the nerves and muscles provides the basis for its therapeutic use.

In normal man, the desire for movement of the extremities originates in the cerebral motor area. For various reasons, such as trauma, cerebral hemorrhage, congenital deficiencies or tumors, the neural path between the cerebral center and the muscles may be disrupted or damaged. Such a lesion causes partial or total loss of voluntary control over muscles thus producing paralysis.

The symptoms of a neural lesion will vary from person to person; however, there are general symptoms, depending on the site of the lesion. If the lesion occurs in the brain, the clinical picture may be of hemiplegia, parkinsonism, or cerebral palsy. Lesions in the spinal cord produce quadriplegia when the cervical levels of the spine are affected, and paraplegia when thoracic or lumbosacral spinal levels have been damaged or interrupted. Nerve impulses along the spinal cord may also be impaired by the destruction of the myelin of the nerve tissue because of multiple sclerosis or similar conditions. Peripheral nerves may be damaged with resulting flaccid paralysis and deterioration of the lower motor neurone. Various muscle disease also cause paralysis.

The basic premise of functional electrical stimulation, however, is that a viable muscle, even though atrophied, can still be indirectly or directly activated and controlled.

The FES principle is illustrated in Figure 1 and works in the following manner. If the path between brain center one (C1) and muscle one (M1) has been damaged somewhere along the way, how can M1 be activated and still be kept under voluntary control? Assume there is another brain center, brain center two (C2) which has an intact neural control over muscle two (M2) which is not indispensable in activities of daily living. If a natural (inborn) or operant conditioned (learned) liaison from C1 to C2 can be obtained, the activation of C1 results in the contraction of M2. Such a contraction is manifested with myoelectric signals or changes in the pressure position of the extremity. Any of these signals which are called control signals (CS) may be used as inputs to an electronic processor (EP) whose output are electrical stimulation signals for M1. If the patient now wants to contract M2 he "thinks" of activating C1 which causes activation of C2, contraction

of M2, generation of control signals (CS), and ultimately contraction of M1 due to electrical stimuli. Thus an electronic bypass of the neural lesion has been established enabling the patient to regain, at least partially, voluntary control over lost muscle function.³

In other words, rehabilitation is composed of a process of learning (or relearning) and adapting a single neuromuscular system to repeated stimuli from the environment. If these are repeated, programmed, and used continuously for a long time, as in the case of functional electrical stimulation, control of lost muscle is made possible.

The primary goal of functional electrical stimulation is to achieve useful muscle contraction in paralyzed extremities by direct stimulation of the motor nerve. It has been observed, however, that during stimulation of the peroneal nerve to correct gait in a hemiplegic patient, more complex mechanisms might be activated than just simple motor nerve stimulation. Apparently, the stimulation signal does not act only on the motor nerve, but also has some indirect effect on the spinal and brain structures. This stimulation changes the excitability of the spinal motoneuron pool in such a way that volitional signals from the brain may again activate the muscle in some people with incomplete lesions. Finally, there are situations, especially in paraplegic patients, where stimulation of some afferent nerve may trigger complex movement patterns (e.g., dorsiflexion of foot and flexion of knee and hip) which can be used functionally during gait.⁴

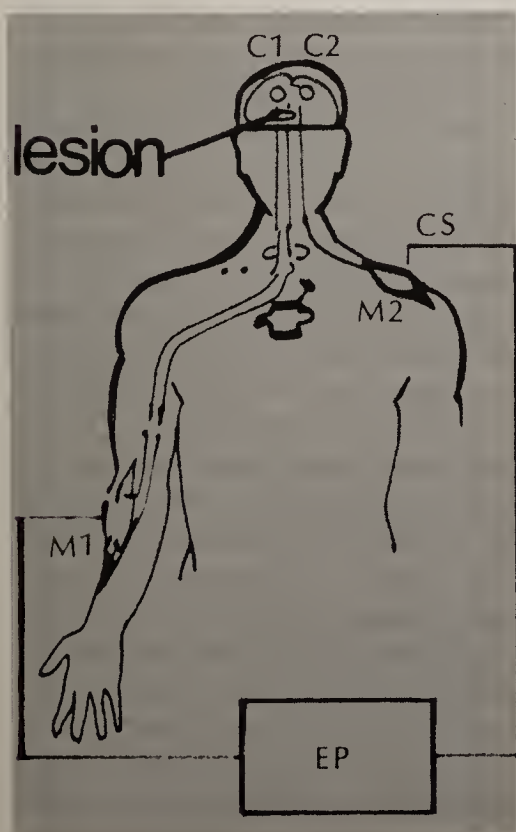
Clinical gait observations at the Ljubljana Rehabilitation Engineering Center showed that FES is effective in the correction of equinus, varus, knee extension in the swing phase,

correction of hyperextension, external rotation of the hip in the stance phase, plantar flexion of the ankle in the stance phase, circumduction of the hip, insufficient knee flexion in the swing phase, pelvic drop on the nonstimulated side, unstable knees, etc. There were significant improvements in the symmetry of leg swing phase time in the majority of patients and also in the symmetry of the stance phase time in nearly all of them.

Through electrical stimulation of the paralyzed extensor muscles and the use of arm support, paraplegic patients are able to rise independently from their wheelchairs. Electrical stimulation of knee extensor muscles in both legs allows standing. Standing for more than one hour, with arm support, can be done safely after a 2-month muscle strengthening program using cyclic electrical stimulation.

Complete paraplegic patient gait was synthesized by using a four channel surface functional electrical stimulator. The initial gait pattern was divided into a double stance phase and a swing phase (swing through). During the double stance phase, both knee extensor muscle groups were stimulated, providing muscle contractions that were sufficient to support body weight. The swing phase was achieved through excitation of the flexion synergistic response. Biped walking was restored in five complete paraplegic patients. Positive side effects noted were bladder sensation, more frequent defecation, and more effective control over partially innervated trunk muscles.⁵

The effectiveness of stimulated gait in paraplegic patients is dependent upon the quality of the stimulation technology, the number of muscles to be stimulated, and the number of electrical signals controlling gait. It is



known that approximately 52 pairs of muscles participate in the walking process. When properly controlled by the nervous system, they promote an effective and stable gait pattern. It is estimated that the process of walking, with its 20 degrees of freedom, needs about 2,000 bits of information per second. FES orthoses, however, transfer a small amount of control information to the system. A one channel stimulator, controlled by a heel switch (on-off principle), is widely used for the correction of hemiplegic gait. When the foot is in contact with the ground, the switch is off and the stimulator generates no pulses. In the swing phase, the switch is on and the stimulator sends electrical pulses into the peroneal nerve to correct the lift of the ankle until the foot touches the ground again. Such a stimulator, therefore, is controlled by one bit of information on the status of gait. To improve control over the stimulation sequences, several foot switches could be applied.

With severely impaired gait, as in paraplegia, a one channel stimulator would not provide satisfactory results. Multichannel stimulators are being introduced into rehabilitation therapy that permit stimulation of multiple muscles. For example, in the Ljubljana Rehabilitation Engineering Center, a six-channel stimulator has been developed that permits the stimulation of six muscle groups. However, even with such a stimulator, a relatively small number of muscle groups that participate in walking can be controlled. The possibility of mounting 12 pairs of electrodes and selecting the proper stimulation sequence exists.

From the control point of view, the greatest deficiency of the functional electrical stimulation system, at the present time, is the use of preselected stimulation sequences regardless of

the actual position of the stimulated leg during walking. Since the stimulation sequences are preselected, this kind of control permits a more or less deterministic walking process. From the cybernetic point of view, such gait is rather primitive. Secondary effects of stimulation that can influence the improvement of gait via the afferent nerve paths appear to be more promising.

Based on the promising results of the application of functional electrical stimulation to correct paratic gait in hemilegic patients, a number of FES systems have been developed that possess different functional characteristics. Their clinical applications have spread to other groups of patients so that this method is now successfully applied with cerebral palsy children and, to a smaller extent, with people suffering from multiple sclerosis. Current investigations are focusing on applying FES to control hand movements in people with high spinal cord lesions, as well as to control standing posture and gait sequence. A special field is represented by the control of functions of the neurogenic bladder and stress incontinence.

Results of these and other investigations have promoted development of more effective rehabilitation tech-

niques and objective evaluations of FES effects. In some patients with lesions of the central nervous system, these techniques not only help to select the method and the therapeutic effect, but also help to prognosticate the rehabilitation results with respect to the impaired motor functions. For example, FES is not yet suitable for people with dyskinesias with or without dystonia or hyperkinetic syndrome. FES is not effective in patients with flaccid paralysis of central origin. However, positive effects of FES on motor activity of patients with central motor lesions have been reported in cases where all other methods had failed.

This can possibly be explained as a probable reorganization of the interneuron system resulting from the repetition of a programed and reinforced neurological inflow from the periphery created by functional electrical stimulation. This new information creates new motor patterns, often not as malleable as in normal people, yet adequate enough for the performance of certain gross movements such as the mechanics of walking.

There are numerous advantages in using FES over other rehabilitation methods for the spinal cord injured. First, environmental barrier problems can be more suitably reduced by regaining some degree of non-wheelchair locomotion. FES is often less expensive, more functional, and more attractive to the patient than the wheelchair. Often, no external support for force transfers with levers are needed for FES orthopaedic devices. The muscle provides the self-regenerating energy supply and electrical stimulation is used only for triggering and sustaining muscle action.

It must also be noted that even a number of years after a spinal cord injury, certain reflexes and gross extension and flexion patterned reflex-



ive movements are initiated as proof that neuromuscular functions are intact distal to the lesion and that they have not been destroyed during the acute incident because of surgery, physical handling, edema, etc. Rehabilitation can, therefore, be provided long after the initial injury.

In practical use, difficulties are being encountered due to technological problems in its application and its use. Some of the problems are related to insufficient biomechanical, neurological, and technological knowledge. Because of these problems, the area is being investigated further.

Ms. Cromar is a research analyst in the National Institute of Handicapped Research.

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PUBLICATIONS & FILMS

New Publications for which content reports cannot be listed are carried below. The publisher and his address is listed first and then the publication and its price.

• Human Sciences Press, Inc., 72 Fifth Avenue, New York 10011.

Addictive Disorders Update, Alcoholism, Drug Abuse, Gambling. Volume VII, Problems of Industrial Psychiatric Medicine Series. Series editor, Sherman N. Kieffer, N.D. \$24.95.

Control Over Intoxicant Use. Pharmacological, Psychological, and Social Considerations. Norman E. Zinberg, M.D., and Wayne M. Harding, Ed.M., editors. \$19.95.

Family Intervention With Psychiatric Patients. Raymond F. Luber and Carol M. Anderson, editors. \$18.95.

Schizophrenia In Focus. Guidelines for treatment and rehabilitation. David Dawson, M.D., Heather Munroe Blum, M.S.W., and Giampiero Bartolucci, M.D. \$24.95.

Borderline And Acting-Out Adolescents. A developmental approach. Gary Nielsen, Ph.D. \$26.95.

Resistant Interactions. Child, family, and psychotherapist. Robert J. Marshall, Ph.D. \$26.95.

• Jossey-Bass, Inc., P.O. Box 62425, San Francisco, CA. 94162.

Deinstitutionalization. Leona L. Bachrach, editor. \$7.95.

• Charles C Thomas, 2600 South First Street, Springfield, Illinois 62717.

Communication Systems For Severely Handicapped Persons. Brenda C. Fairweather, Donna H. Haun, and Louis J. Finkle. \$15.75.

• Oxford University Press, 200 Madison Avenue, New York, New York 10016.

Locomotor Disability In General Practice. Malcolm I.V. Jason and Raymond Million. \$24.95.

• The Haworth Press, Inc., 28 East 22 Street, New York, New York 10010.

Aquatics: A revived Approach To Pediatric Management. Faye H. Dulcy. \$19.95.

Annual Review of Rehabilitation. Elizabeth L. Pan, Ph.D., Thomas E. Becker, Ph.D., and Carolyn L. Vash, Ph.D., editors. Springer Publishing Company, 200 Park Avenue South, New York, New York 10003. 336 pages. \$42.

Twenty authors contribute to the ten papers that make up this third volume of rehabilitation review. Its subjects span an array of interests, from international economics of disability to a state of the art in rehabilitation psychology and a discussion of VR in profit-making organizations to an evaluation of rehabilitation continuing education.

In its introduction, the editors review the master plan for the series and present a prospectus for the next volume.

Vocational Evaluation, Work Adjustment, And Independent Living For Severely Disabled People. Robert A. Lassiter, Ph.D., Martha Hughes Lassiter, Ed.D., Richard E. Hardy, Ed.D., J. William Underwood, Ph.D., and John G. Cull, Ph.D. Charles C Thomas, Publisher, 2600 South First Street, Springfield, Illinois 62717. 440 pages. \$37.50.

The three main areas announced in the title are commented upon in a variety of subdivisions by a variety of authors.

Center Staffed By Disabled Professionals



Disabled professionals, Hiram Zayas (above) and Allen Piening (below) at the center which they manage.



personnel are fully trained, experienced rehabilitation professionals. A significant number of the center's employees are disabled persons. Our own disabilities provide us with an important emotional understanding," Mr. Zayas said.

"We like to say that we have an intimate acquaintance with severe disabilities," added Allen Piening, CIR vice president and Mr. Zayas' partner. Mr. Piening, a rehabilitation psychologist, lost the use of his legs at the age of 13. "We are actively soliciting additional disabled rehabilitation professionals to add to our growing staff," he said.

The center expects to serve a portion of a disabled population of over 250,000 persons in its immediate area. According to research figures compiled by the Illinois Department of Rehabilitation, there are over 720,000 disabled persons in DuPage and Cook counties.

Financed with a \$350,000 loan from the Small Business Administration, "The center provides an excellent opportunity for skilled businessmen to succeed, despite significant disabilities," said Rich D. Durkin, SBA's midwest regional director.

"The loan indicates that government does, indeed, have a heart. More importantly, it indicates SBA's desire to help businessmen help themselves and their community," he added.

In addition to its extensive program of rehabilitation services, the center also offers seminars for the disabled and their families, physicians and insurance executives. It also features Spanish-speaking rehabilitation professionals on staff and a van complete with lift.

"The fact that we're 'owned and operated by' simply reaffirms the principles and goals of rehabilitation services," Mr. Zayas said.

The first comprehensive rehabilitation program in the U.S. to be owned and operated by severely disabled rehabilitation professionals has announced its opening. The Center for Individualized Rehabilitation—located at 2358 Hassel Road, Hoffman Estates, Illinois—offers a complete rehabilitation program, including a

low vision clinic, physical therapy department, occupational therapy department, orthotic/prosthetic clinic, and a speech and hearing service.

"We emphasize vocational rehabilitation as well as physical rehabilitation as part of our ongoing services," explained Hiram Zayas, a multiple amputee and president of CIR. "CIR

Sexuality And Arthritis: Living And Loving With A Chronic Disease

Peter G. Mathon

The “body beautiful”—we are surrounded by it in books and magazines, on television and in the movies. It’s an ideal of physical perfection that is out of reach for most of us. Sex and sexuality are openly accepted and discussed, but our culture implies that these areas of personal fulfillment are only for the physically attractive.

What happens then if you’re afflicted by a chronic, disabling disease such as arthritis? Arthritis is often perceived as a disease of old age, but in its worst forms—such as rheumatoid arthritis, lupus, and spinal arthritis—it typically strikes during the young adult years, between the ages of 20 and 45. One group of arthritic diseases, collectively termed juvenile arthritis, strikes children as early as infancy and can seriously affect the adolescent years when a child is maturing sexually.

In all, the more than 100 different forms of arthritis affect over 31 million Americans. Many of these are people in the prime of life, and half are under age 60. Sexuality is important to them, as well as to older people with arthritis whose sexual activities continue. Although people with chronic diseases or disabilities are sometimes assumed to have less sexu-

al desires than the able-bodied, sexuality does not disappear with illness—no matter how much the illness may interfere with sexual fulfillment.

Body And Mind

Arthritis affects sexuality in a variety of ways, both physical and psychological. The most common of its physical symptoms occurs in the joints, which can be troubled with chronic pain, stiffness, and visible deformity.

Other physical manifestations may include: pronounced rash caused by lupus; recessed chin, often resulting from juvenile arthritis; the dryness of Sjogren’s syndrome, which is associated with many rheumatic diseases and may cause insufficient natural lubrication in the vagina; changes caused by the drugs used to treat arthritis, ranging from the “moon face” and obesity resulting from long-term corticosteroid use to loss of libido; and fatigue, which can be as limiting as pain and is often most pronounced at the end of the day, after activities have taxed the patient’s energies.

“Pain, deformity, and loss of function can make it difficult to feel good about your body,” says Dr. Frederic C. McDuffie, senior vice president of

medical affairs for the Arthritis Foundation. “Such bodily changes can destroy an individual’s self-image. That’s at the core of many psychological problems related to sexuality in persons with chronic diseases.”

Speak Up

Almost everyone can enjoy his sexuality, despite the complications imposed by disabilities such as arthritis. Establishing a successful relationship depends on a great deal more than physical appearance or capabilities. To a large degree it depends on communication.

“Without clear communication, assumptions are made that may be completely untrue,” says Beth Ziebell, Ph.D., an Arizona psychologist who has worked extensively with arthritis sufferers. “For example, Mary has arthritis—Mary and John are not having sex. Mary *thinks* John no longer finds her attractive. John *thinks* Mary is afraid of pain. John and Mary may carry these mistaken assumptions for the rest of their lives unless one takes the risk of directly asking the other.”

It can be very difficult to start talking about sexuality, Ziebell points out, especially if an individual is accustomed to using nonverbal ways of communicating feelings, such as with

eye contact or a special smile.

"Generally couples with a good, solid relationship and clear, honest communication continue to find mutually satisfactory means of expressing their sexuality, even after one of the partners develops arthritis or some other disability," says Ziebell. "Teaching new positions for intercourse will not change anything unless the couple can talk to each other."

Discussion is equally important when a person with arthritis is beginning a new relationship. The individual has a responsibility to explain his physical condition and his feelings, and to let the new partner know what he can and cannot do sexually.

Planning Ahead

While sexuality involves much more than sexual intercourse, it can be a special concern for persons affected by disabling disease.

The famous motto, "Be Prepared," applies particularly well to sexual expression for people with arthritis, says the Arthritis Foundation's Dr. McDuffie. Just as arthritis sufferers must plan their schedule to conserve energy for the activities they most want to pursue, many find it helpful to plan sexual activity.

"It is a myth that sex must be spontaneous to be enjoyable," says Barbara Figley, a physical therapist at the University of Michigan Arthritis Center who specializes in sexual health counseling.

People with arthritis can plan to spend time with their partners when they are at their best—for example, in the middle of the day, after morning stiffness has worn off and before the day's activities cause fatigue. If midday arrangements are not practical, a person with arthritis may plan

to take a few hours off occasionally, or schedule a romantic weekend.

"You're more likely to enjoy sex if you are relaxed and comfortable," says Figley. "Do whatever necessary to reach that point—have a warm shower, take pain medication, share a massage or do exercises together."

Sexual activity may actually alleviate arthritis pain temporarily, according to the Arthritis Foundation. Recent studies have shown that many arthritis sufferers experience relief of pain after orgasm, lasting from thirty minutes to several hours. Researchers speculate that sexual activity, especially orgasm, stimulates the pleasure zone of the brain and releases endorphins, the body's natural painkillers.

Even with planning, a person with chronic disease may no longer be able to comfortably enjoy the kind of sexual activity they were accustomed to. This is when it can be especially rewarding and satisfying to experiment with your partner to find new ways of sharing sexual experiences.

Figley emphasizes that people with arthritis or other chronic diseases should talk freely with their doctor about concerns related to sexuality.

"There are some issues that a doctor must help you with," she says. "For example, unless you ask, you may not learn that one of your medications may be causing loss of sexual desire. Consult also about special family planning and contraceptive advice, and for recommendations about products such as lubricants which can make sexual activity more comfortable."

Dr. McDuffie at the Arthritis Foundation suggests that people keep their disabilities in perspective: "In coping with chronic diseases such as arthritis, sexuality may sometimes present problems, but the problems need not be insurmountable."

"Men and women with disabilities

are first men and women. With necessary information and understanding, people with chronic illness can lead full, personally-satisfying lives," concludes Dr. McDuffie.

Mr. Peter G. Mathon is Vice President/Public Relations, Arthritis Foundation, 3400 Peachtree Road, N.E., Atlanta, Georgia 30326.

COMMENTARY

... On Food Service

The article on "Staffing Food Service Operations" in the April-May-June 1983 issue by A. Philip Nelan, was excellent. However, there was an error on the references on page 20. The Work Station in Industry program at Nebraska Methodist Hospital in Omaha, Nebraska is run by the Eastern Nebraska Community Office of Retardation (ENCOR), not the Nebraska Network of Training Services.

The Nebraska Network of Training Services is located at Meyer Children's Rehabilitation Institute, 42 and Dewey Avenue in Omaha, Nebraska and provides training and technical assistance to programs serving persons with disabilities. This service frequently assists programs in learning how to develop work station and vocational programs. The Network has just recently published a booklet entitled "The Unsheltered Workshop, a Guide to Establishing Work Stations in Industry," and also a slide-tape presentation to use with employers to promote the concept of training persons with disabilities on the floors of local industry. **Lois R. Rood**, Project Officer, Nebraska Network of Training Services, Omaha.

REPORT RESOURCES

A MANAGEMENT CONTROL SYSTEM FOR REHABILITATION MANAGEMENT, MANAGEMENT CONTROL PROJECT—FINAL REPORT. (Grant #G008003051/NIHR). Final Report of the Management Control Project, The University of Georgia, Athens, Georgia.

The goal of the Management Control Project is to demonstrate the optimal rehabilitation agency performance through the application of a management system which eliminates unnecessary and spurious controls and uses performance standards maintained by skilled managers. Based on external performance review results and the analysis of survey data, operationalizing the management control system in three state rehabilitation agencies has resulted in: 1. a significantly increased percentage of accurate eligibility decisions; 2. a significant improvement in the provision of services consistent with the client's total rehabilitation need; 3. a significant increase in agency fiscal accountability; 4. a significant increase in counselor perception of freedom to accomplish assigned tasks without supervisory interruption; and 5. a significant increase in counselor perception of control over accomplishing their work.

The project research and demonstration experience has generated expertise and materials having implications for the rehabilitation community: 1. a mechanism through which an agency is able to assess organization environment, structure, operations, and performance; 2. a format for organizational planning; 3. a program of management skill development in the areas of performance management and team development;

4. a program of counselor skill development in the application of performance standards; 5. a program evaluation design to assess the effects of the management control system.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.W., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

PREDICTIVE CRITERIA FOR REHABILITATION OF COPD PATIENTS. (Grant #G008003026/NIHR). Final Report of the Nebraska COPD Rehabilitation Project II, University of Nebraska Medical Center, Omaha, Nebraska.

Ninety patients with Chronic Obstructive Pulmonary Disease (COPD) participated in a multidisciplinary, 12 day pulmonary rehabilitation program designed to study the factors associated with the vocational rehabilitation of patients with COPD. Clinical, physiological, and psychological measures were used to assess rehabilitation potential.

Those patients who would most benefit from VR programing were successfully isolated. The research suggests that the COPD patient's decision to work following their rehabilitation is based on the individual's age, desire to work, emotional and intellectual status, and degree of physical impairment. Regardless of vocational status, age, or severity of the COPD impairment, almost every patient reported subjective improvement following treatment.

For copies contact: Sharon McFarland, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.W., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

A COMPREHENSIVE MEDICAL REHABILITATION APPROACH FOR SEVERE BURNS. (Grant #G008003018/NIHR). Final Report of the University of Texas Medical Branch.

The project objectives were to: 1. Define the natural causes of burn injuries in terms of the variables which contributed to the accident, such as the time and place and the sources and vectors of heat energy; 2. Identify problem areas in the physical, psychosocial, and vocational rehabilitation of the burn patient, both during hospitalization and after discharge; and 3. Develop a comprehensive model for the optimal rehabilitation of the burn patient which will reintegrate him/her into productive community life.

The report includes discussion of the model program and general conclusions derived from the research with suggestions for further research.

For copies contact: Sharon McFarland, National Rehabilitation Center (NARIC), 4407 Eighth Street, N.W., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

CHILDHOOD DISABILITY: PREVENTION AND REHABILITATION AT THE COMMUNITY LEVEL. Deborah Linzer, NIHR, Room 3431, 330 C Street S.W., Washington, DC 20202.

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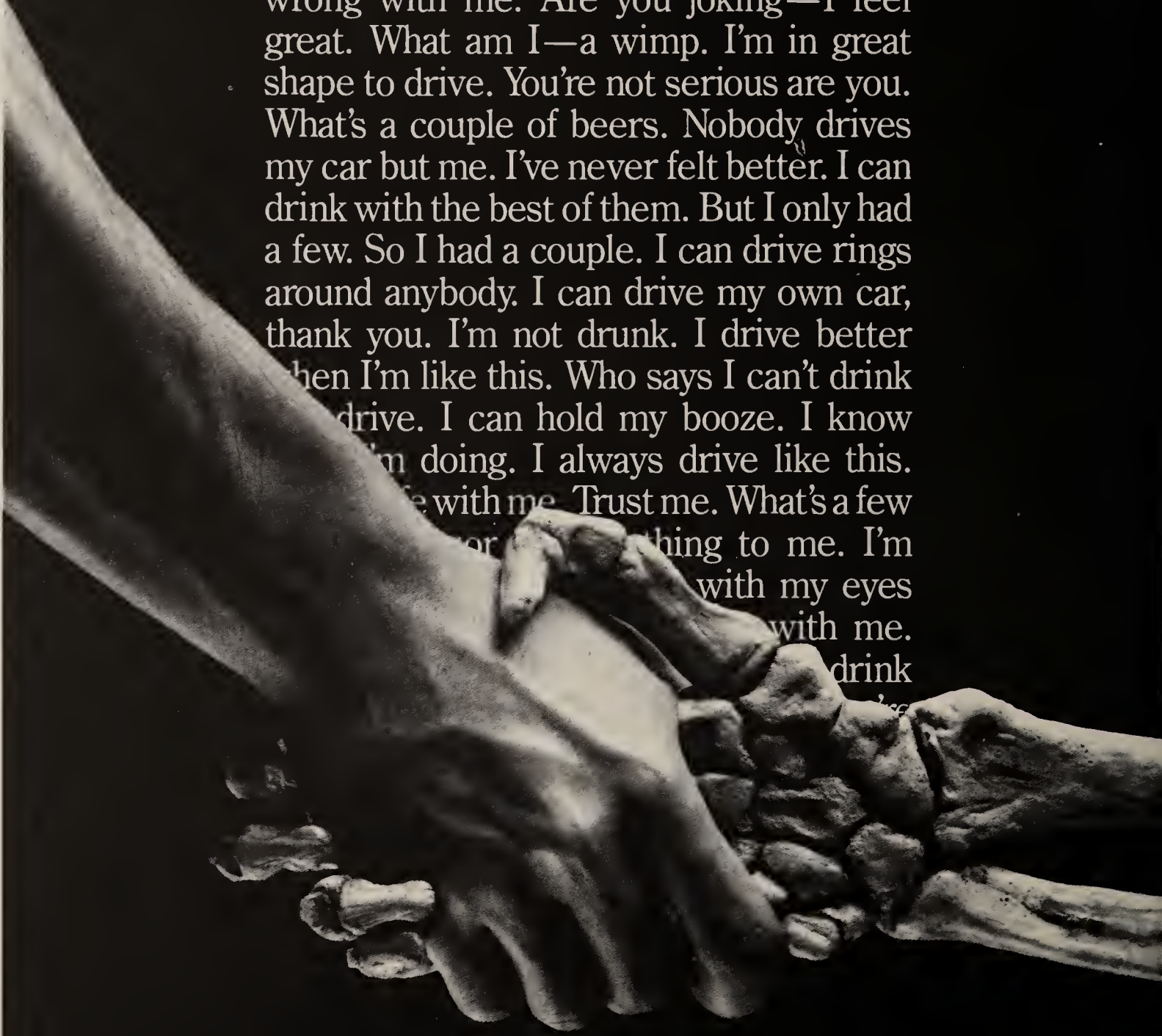
Rehabilitation Tomorrow

**Today's
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Yesterday**



July-August-September 1984
AMERICAN REHABILITATION



FAMOUS LAST WORDS FROM FRIENDS
TO FRIENDS. I'm perfectly fine. I can
drive with my eyes closed. There's nothing
wrong with me. Are you joking—I feel
great. What am I—a wimp. I'm in great
shape to drive. You're not serious are you.
What's a couple of beers. Nobody drives
my car but me. I've never felt better. I can
drink with the best of them. But I only had
a few. So I had a couple. I can drive rings
around anybody. I can drive my own car,
thank you. I'm not drunk. I drive better
when I'm like this. Who says I can't drink
and drive. I can hold my booze. I know
what I'm doing. I always drive like this.
Come with me. Trust me. What's a few
more drinks. Nothing to me. I'm
fine with my eyes
closed with me.
I can drink
and drive.

**DRINKING AND DRIVING
CAN KILL A FRIENDSHIP**

AMERICAN REHABILITATION

Volume 10, No. 3

The weakest ink is better than the strongest memory.

July-Aug-Sept 1984

2	Futuring: Fact Or Fairytale?	Ron Bourgea
---	------------------------------	-------------

3	Accommodations Circa 2000	Frank Bowe, Ph.D., and Neal Little, Ph.D.
---	---------------------------	--

5	Private Rehabilitation: Emerged or Emerging?	George T. Welch
---	---	-----------------

7	Facilities In The Future	James Allen Cox
---	--------------------------	-----------------

9	Computers And The VR Office	Joseph Moriarty, Ph.D.
---	-----------------------------	------------------------

11	Jobs: Where Will They Be?	David A. Molinaro
----	---------------------------	-------------------

13	Computer As Prosthesis	Douglas A. Fenderson, Ph.D.
----	------------------------	-----------------------------

18	Do We Look To A Deus Ex Machina?	Dennis J. Dunn, Ed.D.
----	----------------------------------	-----------------------

23	From Independent Living to Interdependent Living	Lex Frieden
----	---	-------------

27	Internationally Tomorrow	Norman Acton
----	--------------------------	--------------

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Futuring: Fact Or Fairytale?

Ron Bourgea

The story wasn't all that good. How could it have been if, after these many years, I could not remember its title, its author, or even in what magazine I read it? But what I do remember is that it was about a meteorologist who enjoyed a phenomenal success in his weather predictions, to the annoyance and envy of his fellow professionals. If anything, as compared to his peers, the successful meteorologist was the least trained in the weather sciences. How, then, could he do it?

As the story unfolded, the mystery was unveiled. Mr. Smith (let's call him that) lived with an aunt whose lumbago was a barometer of uncanny reliability on the weather's "goodness" or "badness." Now, Mr. Smith could match that "global" statistic with the more concentrated actions of Shep, his dog of many, many years. If Shep left his doghouse reluctantly, we would have overcast and humid conditions; not leaving it at all marked rain or snow, depending on the season.

On his way to work, Mr. Smith always stopped at the corner kiosk to pick up the morning paper where Mr. Jones, the vendor, confirmed Smith's weather suspicions with complaints (or the lack of them) about his "sinus problem" which the temperature, humidity, and barometric pressure affected by making him "bright and pleasant" or "glum and grumpy." Also, Smith never failed to assess old

Charley's (the bus driver) ideas of what the day would bring. (At that early hour, Charley had plenty of time to talk to his passenger about how easy or difficult he expected this day to be, depending upon the weather he thought would come up as it affected an old war wound.) And, so it went!

All of these "hints" were available to all of the meteorologists, but where Smith left the fold and entered "futuring" is when he analyzed the myriad "trends" of now, today, to form an informed opinion of where that would lead tomorrow—to good weather or bad. While there was a margin of error, of course, the margin was ever reduced by studying a range of reactions, not contenting himself to "crystal ball" gazing nor to be tied down to only the precepts of "scientific" meteorology.

Smith was a "futurist" because he understood the principles that John Naisbitt makes in his book, *Megatrends*: "The most reliable way to anticipate the future is by understanding the present."

We have all heard the clichés that "there is nothing new under the sun," that so-and-so just "reinvented the wheel," the process of "déjà vu," and the acuteness of intuition in the female. While these principles and processes serve their own ends (and may have their own validity), futuring approaches some old notions in new garb. The predilection to garb

"futuring" in the cloak of witchcraft, divining, or other supernatural appellations is as harmful as it is to relegate it to charlatanism, hucksterism, or some such. Call it, if you will, an old method dressed in new clothing. Whatever the semantics, and with today's rapid changes (Alvin Toffler, in his book, *Future Shock*, says that "Change is the process by which the future invades our lives"), the process of prognostication fills a need and gives a guideline to the future if we are sharp enough to "pre-see" the future that is "popping up" here and there in our present. The point is that these "pop ups" in the present are capable of being monitored: Naisbitt's group "continually monitors 6,000 local newspapers each month" to compile its publication, *Trends Report*. Marvin Cetron, who heads Forecasting International, Ltd. and who prefers to think of himself as a "forecaster" rather than a "futurist" deals with "strategic planning, policy analysis, research and demonstration management, resource allocation, and impact assessment." (Diane Stoy, "Trends: The Job Market by the Year 2000" *The Washington Post*, Monday, January 2, 1984.) He makes that term distinction about himself in contrast to what Naisbitt terms "gee-whiz futurists." But, semantics again aside, they are both saying the same thing, *i.e.*, the things they do are not "crystal ball" gazing, nor preference wishing, nor relegations to "faith," but they are based on sound observation and acute analysis.

It is from these sound observations, for example, that Naisbitt can counsel us to "make sure the company you are working for has a long-range view of the future or you may find yourself in one of the next dying industries—or in a company that is dying in a growing industry." And that

Cetron can predict plentiful jobs by the year 2000 in such areas as bionic-implant technicians, technicians for the handicapped, and gerontological aides.

On the basis of "scientific futuring" rather than "crystal ball gazing," we have asked a number of

authors to comment on where they feel, based on their present observations and analyses, the field of rehabilitation is headed as it approaches the year 2000. Obviously, their assessments can only be thumbnail sketches, given the very limited space assigned to their exposition. Nonethe-

less, we hope that in the year 2001, some rehabilitationist will refer to these "bookmarks" and comment that "They saw clearly our present which is now their past."

Mr. Bourgea is Editor, *American Rehabilitation*.

Accommodations Circa 2,000

Frank Bowe, Ph.D., and Neal Little, Ph.D.

First, we hope there won't be many. About this, more in a moment.

Second, we seriously doubt that the kinds of things being developed today in rehabilitation engineering centers and research and training centers will be among the reasonable accommodations on the market in the year 2000. For two good reasons, or maybe three, most of which are evident to the engineers and researchers at these centers today.

Three, those accommodations we do see on the market that year likely will have been developed primarily to meet the needs of older persons. That's where the big market will be.

Fourth, a major source of jobs for disabled individuals that year will be in installing, maintaining, servicing, and adjusting accommodation aids and devices for older individuals.

About Accommodations

Let's keep firmly in mind the concept that accommodations are adjustments, changes, special peripherals or add-ons, made to some standard, mass-market product. The basis for development of accommodations in the first place is that the assembly-

line, cheap, readily available, quickly repairable devices and equipment that most people buy aren't suited to meeting the special needs of persons with disabilities.

Pause for a moment to consider the ironies.

Almost by definition, the term "accommodations" suggests the aftermarket new-product introduction.

Funny thing about accommodations is that they are almost always exactly what they should not be. First, as compared to general-market devices, they're extremely expensive. Case in point: talking calculators. Specialists in rehabilitation engineering worked long and hard to produce a calculator blind people could use. The price when they were brought to market, was well over \$400. Meanwhile, an electronics company came out with a very similar machine, this one designed for use by John Q. Public. Cost: \$50.

Similarly, they're very hard to get serviced and repaired. You're lucky if the people who made the device are still around when it needs to be fixed. More likely, they've scattered to a dozen different locations. No one at the center where the device originated

remembers how to fix it. By contrast, mass-market devices can be fixed by taking them to a local hardware store, to the store where you bought the product, or just to your mailbox. Some, like calculators, you may not even try to repair. They're so cheap that you'll just buy a new one.

Third, it's hard for the average individual to find out about available accommodations. Unless you have a rehabilitation counselor who's willing to spend a few months on the case, you may never learn what's out there. Case in point: aids developed to help persons using wheelchairs to take down objects from high shelves. Quick, now, where can you buy one? By contrast, mass-market products are everywhere. Walk into your local general store and there it is. Part of this has to do with allocation of advertising costs. When some clever folks in Colorado produce the AbilityPhone, (TM) they knew they had a good product. It was a year before we found out about it. The greatest market penetration they achieved, as far as we know, was a "new and interesting" mention in a magazine devoted to home electronics. When AT&T introduced the Emergency Calling System fire and medical alert signalling aids that did some of the things the AbilityPhone does, full-page ads in every major consumer magazine and metropolitan newspaper in the country made millions of people aware of them the first week the products were on the shelves.

Obviating The Need

The general principle we hope will be followed is one of making mass-market products "accessible" in the research and development phase. That way, most everybody can use them, including most handicapped persons. Result? Disabled individuals, just as other consumers, benefit from the low prices, easy availability, ready repair and saturation advertising that are associated with mass-market products.

Will that happen? We think so.

Consider, for example, computers. The personal computer makers were selling millions of these remarkable machines with little if any thought being given to handicapped people. This time, unlike so many times before, engineers and researchers concerned about the needs of handicapped people started a dialog with the major computer makers, early in the game. By 1985, you'll see more personal computers coming out that are accessible from the word go. The problem, it turned out, was simple. The expertise on how to make computers accessible didn't exist in the manufacturing companies. They were more than willing to cooperate, but first someone had to teach them what to do. We think we'll see more of this kind of "preventive advocacy" in the future. It sure makes a lot more sense than after-the-fact advocacy that seeks to tear things down and rebuild them.

Sure, there will always be a small group of people for whom truly special needs will exist. We'll always need accommodations. But when we say that we hope that by the year 2000 there will be relatively few accommodations on the market. What we mean is that the needs of most disabled people will be met in general-market products, so that we need few

special accommodations.

Curiosities

We said that the aids being made in RECs and RTCs are unlikely to be on the market in the year 2000. To us, that's obvious. First of all, they're not on the market now. Someone once estimated that no one aid ever developed for blind people had reached and helped more than 5 percent of blind people. Until the RECs and RTCs become market-driven to an extent unimaginable now, the aids they produce will remain specialty items primarily of interest to other engineers and researchers. Nothing we're saying will be new to our many friends in RECs and RTCs: They've known personally the intense frustration involved in spending years on a device only to see it gather dust on a shelf.

Older People

The over-65 population in the United States comprises 11.3 percent of all citizens in the country. By the year 2000, that figure will increase to 13.1 percent. Translated into real numbers, the cohort will grow from 25 million today to 35 million then. And the growth curve from the year 2000 on is almost vertical: By the year 2050, we'll have 67 million senior citizens.

We don't know enough about how many over-65 people are disabled. But we know something and what we do know is startling. According to the 1982 Current Population Survey of the U.S. Census Bureau, 29.7 percent, or 3 in every 10, of persons aged 65-74 report one or more disabilities. Impairments among individuals aged 75 and over are, if anything, more prevalent.

Simple market dynamics tell us that accommodations, when they are planned and produced, will be aimed

primarily at these older people. By and large, they've got disposable income now that home mortgages have been retired, children's tuition fees have been paid, and other large-ticket expenditures have been made. So they constitute an attractive market for the private sector.

According to Forecasting International, a Virginia trends analysis company, home health care and other services and aids for the over-65 population will be a multi-billion dollar industry by the year 2000.

Jobs Growth

Forecasting International says, too, that jobs involving the manufacturing, distribution, installation, operation, and maintenance of aids and devices for older people will be a major source of employment by the year 2,000. It makes sense to project that many of these jobs will be held by disabled persons: They have life-experience, decades-long training in meeting the special needs impaired older people present. Enough said.

Some Predictions

We won't have telecommunications devices for the deaf (TDDs). We won't need them. Instead, deaf and speech-limited persons will use their personal computers to communicate on the telephone. Computers by the year 2000 will have speech recognition, so deaf people can read on a computer terminal the words someone says on the other end of the telephone wires.

We will have robots in the home and in the office. They'll listen to and understand spoken commands. But will they replace human-being personal assistance aides? We doubt it. Rather, the robots will be used to perform highly routinized, sharply de-

(Continued on page 8.)

Private Rehabilitation: Emerged Or Emerging?

George T. Welch

My projections expressed here on private rehabilitation by the year 2000 are based on communications with many professionals around the United States during the past several years; an extension of plans that are in existence today by the private sector and other interested parties; and my own experience and my tendency to day-dream and plan.

Some assumptions are required to arrive at long term projections. Assumptions should be realistic and based on past history as well as current short term trends. My assumptions involve the future of groups that have a direct impact on the operations of private sector rehabilitation. The insurance industry, the health care industry, American business and industry, and state and federal governments impact the private sector and its future.

There is every reason to believe that the insurance industry will continue to be innovative, aggressive, and highly competitive. To achieve and maintain financial stability and profit for their owners, they must control medical and lost wage cost. The proven name of that game is disability management and rehabilitation.

The American insurance industry, during its history that dates to the American revolution, has responded to the personal and commercial needs and exposures of citizens and business. We can, therefore, expect innovative coverages and methods in

servicing the risks they assume. Insurance must control costs to be profitable or to survive. For example, how much will a day's stay in a hospital or rehabilitation facility cost in the year 2000? Technology and automation will explode in the insurance industry and only those who expand in these areas will survive. It is my assumption the insurance industry will become even more involved than it is today in disability management and rehabilitation.

These same problems will be encountered by the self insured business and solutions will be similar. There will be a growing trend to self-insurance. No person or business, however, will be able to financially retain all its astronomical exposures that are brought on by personal injury, illness, and disease. Today, workers compensation, auto liability, general liability, and employee benefits are the statutory or assumed exposure of a business that develops disability claims. There is no reason to assume that in the year 2000 the impact financially of disability will be any less. If it is to survive, a business must solve the high cost of disability. Tomorrow will be a competitive marketplace for business. It is my further assumption that, like the insurance industry, American business will become greatly involved in rehabilitation, whether self-insured or insured.

The health care industry has an excellent and proud 50-and-more year

record of developing techniques and care that have saved lives and extended life expectancy. This has been achieved by dedicated professionals but at a high cost to the payer. One can expect this trend to continue, except at a lower pro rata cost. This is not to say that health care cost will not increase as inflationary influences in our society drive up all costs. However, competition and other factors will diminish the cost spiral in health care. Scientific technology will continue to progress, resulting in longer life spans. One can expect fewer disabled people if the ultimate is achieved in prevention and care. It would seem prudent to assume the cost of a permanent and totally disabled person to insurance, business, and society will climb dramatically. Therefore, it is my assumption that health care facilities will market the benefit of quality care and rehabilitation to insurance and business aggressively as a cost control vehicle.

Government involvement as a payer source for health care and rehabilitation should decline. Economically the tax base and our deficits will not allow government expansion as a payer. Those government programs that now pay health care and rehabilitation will decline and other sources, such as business and insurance, will increase; that is, while today's total government expenditures may not decline, they will as a percentage to government spending by year 2000.

Services in rehabilitation and other areas will also be reduced due to the economic pressures on government to curtail costs. It is not logical to assume direct services by government in rehabilitation will increase when such services can be supplied more economically by others. Survival in the private sector or rehabilitation depends on the very best service at a competitive cost. There will never be

such a motivation by government rehabilitation workers or programs no matter how dedicated they may be. Private sector can and will supply all services. Government will regulate and supervise the cases on which they are involved. Relatively few government rehabilitation professionals disagree with this assumption.

Therefore, it is my prediction the private sector rehabilitation will grow phenomenally, emerging as the only source of rehabilitation service. Further, I see all providers as for profit and the very word "profit" gaining respectability. In justifying and qualifying this statement, prudence calls for a fierce, business-like competition among suppliers. In such a climate, only well managed, adequately financed, and professionally aggressive service delivery will survive, hence, fewer but larger vendors. Mergers and acquisitions (developmental American business techniques) will come to the field of rehabilitation.

Having for many years experienced for profit, large, well-financed, and well-managed operations in business, industry, and rehabilitation, I feel positive about such a development. Result-oriented and cost effective service will only mean better services to the disabled person, who will be treated as a consumer. Their needs will be paramount.

There are valid beliefs that capital will flow to rehabilitation if government regulation is held to a minimum and the business view replaces the "do-gooder" view of service. The day of conflict between "profit" and "service" will be over! The future requires results by service industries, of which rehabilitation is a part. The consumer will demand results with little regard for the supplier's structure. A supplier will either deliver or go out of business, and another, more able will take his place.

Universities must change their curricula so that graduates effectively meet the challenge of the new marketplace. Many skills will be needed that are not today developed during training. Educators must seek advice more from business people and rehabilitation's private sector than on government in planning their courses. As business supplies more and more of the rehabilitation service, its demands on the university for personnel to fill its ranks will increase. Effective, result-oriented rehabilitation is a people business. Business can finance, manage, and motivate an employee but the employee must be highly trained and prepared, as in other professions, to perform with little or no delay after an orientation program.

If business people do dominate and control the rehabilitation industry in the year 2000, one can expect more and better placements. After all, industry is where the jobs are and business can redesign the work to accommodate the needs of the person. Work in the year 2000 should be lighter in physical scope because of automation and service industries trends.

Much more will be done in prevention of disability whether congenital,

traumatic or from disease.

However, this could be balanced in numbers by accelerated life style and increased leisure time. The best projection would be to expect about the same number of disabled people, proportionate to our population increases. Health care facilities and professionals will keep many people alive who would have died. The medical and vocational rehabilitation process will change, responsive to that development. The private sector should thrive in that environment. Planning, in the private sector, has by tradition been reviewed as an important (if not the most important) function of a well-managed enterprise. There is every reason to believe that those who will survive are dealing with long range planning today. Planning is not crystal ball gazing, but, rather, hard and necessary work. I have every reason to believe and expect that the private sector of rehabilitation is today planning for the future, and it will grow and prosper as a result. The beneficiary of today's planning will be tomorrow's disabled person.

Mr. Welch is a consultant in insurance, health, and rehabilitation.

... You can tell you are being educated if your options are increasing, and that the reverse is happening if they are decreasing. Similarly, a society can tell it is growing if the options for its citizens are increasing. John Naisbitt. *Megatrends*, published by Warner Books, Inc., NYC.

Facilities In The Future

James Allen Cox

Radical change is exciting to anticipate, but rarely as significant as the first adrenalin-rush at the thought of it. Flights of whimsey over what may be in the near future beyond 2000 cannot be regarded too seriously, even though that milestone is a scant 16 years away. We should discard both the pessimism of calamity shouldered in rehabilitation in the past few years and the equally erroneous vision of perfectionism which some would suggest will become our field.

As many are noting this year, 1984 is the year that never happened. George Orwell's brilliance notwithstanding, the dire predictions of Big Brother have not happened. Neither will Big Rehab.

Constancy is as important a factor as change, yet so much of "futurism" is preoccupied with how different things will be. Surely we will have impact from change in the field of rehabilitation, but many of today's *constants* will serve as powerful indicators of what to expect. Let's look at the future by examining the circumstances of today which will not change. The shape of our rehabilitation environment in 2084, or sooner, will be based on a number of constants.

Constraints In Resource

Money for rehabilitation services is tight today. It has become increasingly so in the past 5 years with curtailments in government spending and

changes in entitlement rules. It will continue and remain so in the future for facilities, for state government, for consumers. The inevitable pressures this constraint places on our ability to serve people will not be ameliorated by an enlightened Congress nor dramatic economic improvements. It is a constant to be accepted and accommodated within our collective capabilities as managers. Fiscal limitations, *i.e.*, never enough money, will be a constant factor in the future. The challenge, then, is to improve our skills as managers, and as lobbyists.

Efficiency In Output

Beginning with an emphasis on program evaluation, our field has edged closer to performance-based contracting in rehabilitation services. State agencies and other buyers are looking closer at outcome assurances as a component of their purchase-of-service programs. This attention is not a trendy preoccupation of fiscal conservatism, it is a constant, and will remain so.

Facilities of all categories must become more efficient providers of service or they will cease to provide. Buyers of services (government) and users of services (consumers) will require results with their rehabilitation service experience. Facility providers of quality, cost-effective, results-oriented outcomes will be the mainstay of our rehabilitation system.

Economy In Government

No two words raise more ire in some rehabilitation meetings than "block grant." Let's not indulge in semantics, a constant has been revealed and we should recognize it. That constant can be defined as the striving for economy in structure of the bureaucracy which implements our programs. It will not go away. We can expect smaller, more consolidated government structure, both federal and state, with limitations on the amount of appropriated funds which will go for employment of government to administer/serve. The trend of spending a greater portion of funds on administration than on service will stop. Less government overhead and more direct services will be the future.

Self-Reliance In Communities

People in communities "own" their problems and needs. Naisbitt tells us people will have fewer expectations on institutions of government. This will be coupled with a greater sense of local responsibility in solving local problems. People in communities will make more of the decisions about the type and structure of services. Perhaps with state or federal money, but certainly with local decisionmaking. Centralized federal and state structures will be less important. The constant is already apparent; it will become increasingly so.

Constancy In Service

Community-based organizations will continue to serve as hubs of service to people in need, or components of a network of service. Whether or not facilities are the same form or name as today, they will continue to be vital instruments of service in our communities. That is a constant

which has remained throughout the history of charitable, not-for-profit evolution, and will continue. Communities will need the role facilities performed as catalysts of community needs and capabilities, regardless of changes in nomenclature, emphasis, disabilities, or programs. Today's facilities should expect continued responsibilities in tomorrow's rehabilitation system, but perhaps a new set

of terms, programs or disabilities.

So there you have it: five constants which predict the future. Perhaps you can add more. We have little to fear about the future for facilities or rehabilitation at large. The constants of today are our guides about what to expect tomorrow, and a blueprint for our leadership. Surely great change will also come in many respects. But you can expect these factors to still be

evident in the future; these constants to prevail. Issac Asimov, the noted author, said it best: "If we can conquer our follies, hates and fears, and refrain from destroying ourselves in the immediate future, the horizons beyond are golden and endless."

Mr. Cox is Executive Director, National Association of Rehabilitation Facilities.

ACCOMMODATIONS

(Continued from page 4.)

limited tasks that occur over and over every day, freeing the personal-care assistant to perform other necessary tasks for a disabled individual.

We'll have affordable print reading machines for blind persons, so they can pay their bills, conduct their personal affairs, and keep up with the news in privacy. But there will be less print to be read. Computers will talk better than they do now and that will be the major way in which blind people will interact with information.

We will still have inaccessible subways. Buses, too, likely will remain rather inaccessible. Cars are not likely to be made more accessible than they now are. But many severely physically disabled individuals will leapfrog these transportation barriers by using telecommunications and distributed-processing microprocessor-based technologies. To get around, they'll use their personal vehicles. It's not that we don't think we can make transportation systems fully accessible. We can. We could have 5 years ago. But we don't think we will, for reasons having to do with mismanagement of the systems generally and urban economies specifically.

Almost all of this assumes that biochemical and surgical advances don't

obliterate many of the more prevalent disabilities. We're "on the verge" of breakthroughs in many areas.

It should prove interesting to see what happens.

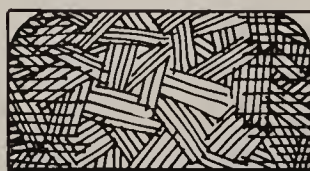
Dr. Bowe is the author of *Personal Computers and Special Needs* (Synbex, 1984). Dr. Little is Associate Professor, University of Arkansas Rehabilitation Research and Training Center. The ARRTC is supported, in part, by a cooperative agreement with NIH.

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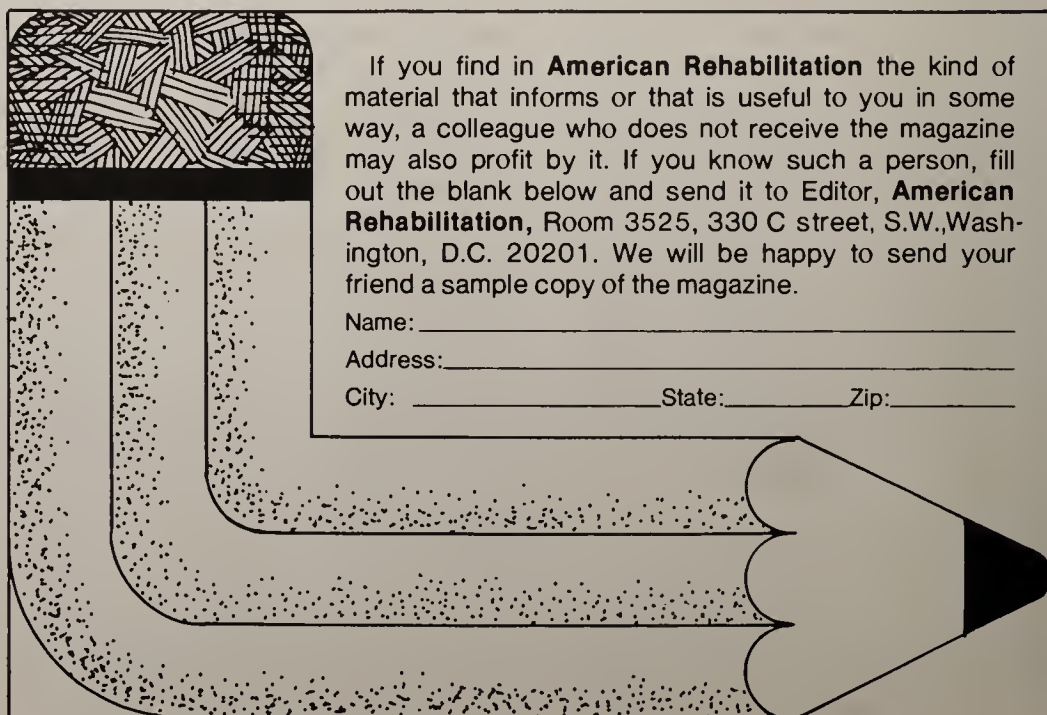


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Computers And The VR Office— A Low Falutin' Approach

Joseph Moriarty, Ph.D.

“Interviewer: Sir, in your opinion, in your 2,000 years what has been the greatest single thing that has advanced the cause of rehabilitation?

2,000 Year Old Rehabilitation Counselor: “Paper.”

—**Film:** “Revelations of a 2,000 Year Old Rehabilitation Counselor”—

Computers are undeniably revolutionizing contemporary society. Nowhere is this more apparent than in the way it is affecting office work. With visions of Buck Rogers being advanced by those who claim to divine the future, it is easy for the rehabilitation worker to be intimidated. I'm here to tell you that yes, there is a revolution afoot, but, no, there is no need to be intimidated by the prospect of same.

Literacy, Yes—Programing? You hear a lot these days about computer literacy. Often that term includes the notion that to be literate I must also learn how to program the computer. This is nonsense. It's like the difference between driver's education and auto mechanics. To make effective use of automotive technology, to make practical use of the automobile, I have no need to learn the eccentricities of the eccentric cam, or become familiar much with the innards of the machine. To be sure, knowing automotive mechanics comes in handy. But it is in no way essential for me to make use of automotive technology to get to the grocery store, take a vacation, drop the kids off at Miss Shields' dance studio, etc. Software packages are already on the market that, with an hour or two of effort, put me in the position to meet a number of my needs. To be sure, we're still in the klutzy era in which soft-

ware companies continue to produce needlessly complicated software. But the market place will either force them to change or die. Increasingly, computer literacy will mean what the term suggests. That is, the ability to understand the basics of what the computer is all about, what its current and future potential is, limitations of the technology, etc. The ability to program will more and more move into the category of nice to know—not have to know.

The Computer Gets Vulgar. I mean vulgar in the root Latin sense of the term, *vulgus* which, translated freely, means ordinary person as opposed to the hoity toity. There's no doubt about it, the computer is getting vulgar. Witness the creeping in of the electronic mouse where, if I don't like using a keyboard, I can scroll an electronic mouse around the screen to get what I need. An even clearer example is provided by the introduction of touch screen technology which lets me get at one of, say, four options—a, b, c, d—by simply touching the option and shazam! it appears. On the output side, synthesized speech has progressed to the point where, if print is undesirable, I can flip a switch and presto! the output now comes to me in a rather pleasant, well-modulated, albeit computer generated voice. If that's not enough, within 3 years, it's a good

bet that computers will be able to transcribe speech, *i.e.*, talk into them and they produce text. This will be a boon to tortured typists like myself for whom the very sight of a keyboard is a put-off. It will also be as significant a step forward for motorically impaired as the synthesized speech is for visually impaired persons. The point? Simply this. If you're scared and put off by computer technology in its current form, don't worry. Relax. Sit back. The technology will come to you and will ultimately be part of your breathing in and breathing out. In fact, if you own a late model car or appliance, you are probably using a microcomputer every time you turn on the key or flip the switch. Take heart, take heart.

Rehabilitation Problems Reconsidered. In the film referenced at the top of this article, the 2,000 year old counselor was overjoyed at the invention of paper because in rehabilitation's primeval days, case recording had to be done on rocks. Casework required a lot of chiseling. In those days of yore, they were probably prone to regard their recording problems as rock problems just as today we talk about paper problems. If you scratch paperwork problems, what you find are really information problems. Paper is simply the medium through which information gets recorded, sent, received, etc. So, for

example, a secretary may complain of the needless duplication of effort when the same identifying client characteristics (e.g., name, age, etc.) have to be retyped on so many different paper forms. While presented as a paperwork problem, what she is responding to is an information problem. With information stored in an electronic form, this particular problem of duplication can be solved. Once data is entered, it can be regurgitated on as many forms to as many people as necessary.

Just like the paperwork problem can be recast in information problem terms, so too can other problems. Take, for example, compliance. Vocational rehabilitation agencies sometimes employ supervisors and others as checkers whose job it is in one form or another to make sure that what is done at the operational level is in compliance with laws, rules, and regulations. Inordinate amounts of time and energy are consumed with reviewers checking on the doers. With automated computer systems, it is possible to prevent such problems from occurring in the first place. Specifically, if laws and regulations stipulate that criteria a, b, and c must be met before a client can receive x, it is possible to design informational systems that will not allow x unless a, b, and c are present. As much as 80 percent of the compliance issues can potentially be dealt with in this fashion—issues that are now handled through supervisory reviews, audits, case reviews, and other procedures.

Counselor Reconsidered. As suggested above, a counselor can be considered a knowledge worker. As a professional knowledge worker, the heart of the counselor's job is decisionmaking. In fact, it can be argued that decisions are to a rehabilitation office what, say, merchandise is to a store. The efficiency and effec-

tiveness with which the counselor processes information sets limits on his/her capacity to make decisions. From an information perspective, an issue like how can the quality of services be enhanced gets recast into how can better decisions be made so that better quality of services results? From this viewpoint the question is not how do you get counselors or secretaries to do this or that better. But, what decisions are made; what information is needed to make those decisions; and, in what form do they need the information? Improving the productivity of a professional knowledge worker is intrinsically tied up with making that person a better decision maker/information processor.

The Office Reconsidered. According to the dictionary, an office "is a room or building in which a person transacts or carries on his stated occupation, distinguished from shop, store, studio, etc." Looked at from the perspective of information, a substantial portion of the transactions that go on in a rehabilitation office have to do with processing knowledge or information. Considered as a unit, both the rehabilitation counselor and secretary get, record, store, send, receive, compile, synthesize, interpret, and act on information. Viewing the rehabilitation office from this perspective allows us to see the common thread of information handling that runs through both counselor and secretary roles. Such a viewpoint also softens some of the historical dualism that has been ascribed to the counselor role. Whether acting as a counselor as such or as a case or caseload manager, counselors are in the business of processing and acting on information. In fact, what seems to distinguish an office from a "shop, store, studio, etc." is that unlike them, the office does not deal with tangibles but largely with the intangi-

ble commodity of knowledge or information.

The Computer Reconsidered. There is a tendency for every new technology to be defined in a rather limited way in terms of existing technology. Time was when the car was referred to as a horseless carriage. Of course, the evolution of the car in time made its definition in terms of a horse irrelevant. So too with computers. Their very name is a throwback to the post World War II days when this new technology was primarily applied to number crunching. It was an exceptionally fast computer; hence, the term. As with the horseless carriage, however, the time has come to uncouple the technology from its past to see it in a much broader scope. In fact, the computer is a knowledge/information processing machine that has broad application across a whole gamut of information processing—getting, receiving, sending, etc. For example, as of this writing, there are over 1500 on-line data based/information systems covering just about every imaginable topic. Many of these systems are publicly accessible through computer and phone hookup. Hence, anyone, anywhere with a computer terminal or desk top computer can have fingertip access to a global encyclopedia of information on almost any topic. More specifically, the Eleventh Institute on Rehabilitation Issues has developed a computerized data base dealing with placement systems. This data base (LIPS) is available to any counselor in the United States providing products, systems, and methods that are in any way related to placement of disabled persons. These data bases and access to same via computer illustrate how the technology is much better thought of in broad, information processing rather than just in number-crunching terms.

As a further illustration, consider the shape of things to come as computers move into move from software to what is coming to be termed knowledgeware. Horton (1984) notes "Until now, we have programmed the user to exploit the machine. In the future, we must reverse the process—program the machine to exploit the potential of the mind. That is knowledgeware." Horton's futuristic thinking is already being reflected in the development of expert systems. For example, systems such as MYCAN represent computer guided

diagnosing of bacteria and prescription of appropriate antibodies. Another computerized medical system, INTERNIST, achieves the same objective except on a broader scale of internal medicine generally. While such systems are not without flaw, they do reflect the shape of things to come in computer developments. Findings with these expert systems are that they typically do as good as and in some cases better than their trained medical counterparts.

"Software exploits the power and versatility of machines. It not only

helps us 'do the thing right,' it also helps us 'do the thing well.' But that still isn't enough. We must also learn to do the right thing." (Horton, 1984)

It is the pursuit of this sometimes elusive goal, doing the right thing by, with, and, where necessary, for disabled persons that will constitute the ultimate test of the computer's contribution in the VR office. The future looks bright.

Dr. Moriarty is Director of the West Virginia Research and Training Center.

Jobs: Where Will They Be?

David Molinaro

It depends.

Some forecasters say smokestack jobs (steel, rubber, autos, etc.) will either

1. *be* in another country—lured there by lower labor costs. *Made in Japan or Taiwan* isn't funny anymore.

2. *be* greatly reduced in number—because robots work very well—for long periods and drink less coffee. On T.V., Lee Iacocca touts the new Chrysler Corporation as he stands by an assembly line "personed" by 17 robots—no humans.

Some say jobs will:

3. *be* in the home. Five million people earn a living near their refrigerator now—double that by 1990.

4. *be* at neighborhood work centers. Since phone lines, satellites, and computers frankly will reduce the need to show up every day, corporations will establish "extension work

centers" near employee homes. Several corporations may pitch in and equip shared centers for their employees. We will call such employees—telecommuters.

A lot of people say most jobs will:

5. *be* in the service sector. I think we have all read about the continued growth of such service sectors as leisure, recreation and fast foods... the Big Mac-replaces-Big Steel-type message. Occasionally, it seems like we will be taking in each other's laundry.

The Guinness Book of Nice Tries.

Looking for where future jobs will be is not an exact science yet. We can only characterize such looking ventures as "nice tries." We will allow that each point mentioned above has some truth, to a certain degree. We see bits and pieces of them happening right now and they will probably continue to happen. However, we would

hesitate to rest our job counseling necks on any point or on a collection of some. There are simply too many potential guillotines. For example, one service area, consulting, seems bound to grow and grow. We have consultants in computers, in management, in rehabilitation, in stress control, in proper dress, home-gardening and so on. BE there! Yet, another development may guillotine the consulting trade's growth. This development is called *expert software systems*. Expert systems work like this.

A handful of experts, say in the field of off-shore drilling rig repair, gather together in a cloistered room. They think up all the ways that rigs can break down then all possible ways to fix the breakdowns. They then compose a computer software program called "1,001 Rig Fixes" and sell it to every off-shore rig manager in the world. That expert system is going to hurt at least one consulting field. The same development has hit computer programmers right in the neck. Are even rehabilitation counselors safe?

When job forecasting includes hard data I still think it remains a candidate for our Guinness Book. The Department of Labor recently offered

some hard figures (see table) that capture a jobs-of-the-future hit and dip list—we see big growth in mostly low-paying service categories. This could be interesting news for rehabilitation since the majority of its clients historically take jobs within these growth categories. Couple such data with a sharp decrease in available workers projected by 1990 and the employment potential for rehabilitation clients certainly appears rosy.

When we look at the worst prospects at least one point stands out. Except for the education professions (graduate assistants, college and high school teachers) that are directly affected by the number of teenagers reaching a low point around 1988, most jobs are in the decline because of new technologies such as advanced combines, hybrid seeds, computers and satellites. Even the demand for clergy is subject to the phenomena of *one* preacher serving the needs of

millions through pray T.V. via satellite.

There are an awful lot of words and figures available to us as we peek into the job future. This brief scouting effort has but scratched the surface. It's also apparent that such information does not precisely guide our looking for and finding where jobs will be in the future. All are necessary nice tries and we appreciate what insight they do provide. Looking for and *not easily* finding the specific job picture is certainly a frustrating way to spend one's time. We don't know whether to get mad or do each other's laundry.

Yet, something has been found. Although the numbers of some jobs are either ebbing or flowing—the names of those jobs generally remain the same—farmers, teachers, clerks, typesetters, etc. What this says is the *question* that will help us look deeper and truer into the job future is not only, “*where* will the jobs *be*?”; but

also, “*how* will the jobs *be*?” For instance, although we have information that teaching jobs will soon decrease in number . . . that's just part of the answer. *How* the teaching job will be performed should also be mulled over. At present, on up through high school, we hold the teacher responsible for composing and delivering education and also for guiding the socialization of his/her students. However, the arrival of computer assisted instruction and video-disc technologies will provide students with “expert sysems” in any subject. The best instructor giving the best content in the best instructional way will be available to all students. The teacher will not have to compose and deliver. How the job is performed, therefore, will conceivably change to an emphasis on socialization and individual student support. This change may attract a different personality into the profession. So it goes with many future jobs. Our capacity to forecast the job situation, then, will be enhanced by asking two questions, where *and* how will they be.

P.S. You know, just about all job forecasting either comes from people observing the world of work or from the world of work itself. This fact reminds me of an employer seminar we were conducting. A portion of the seminar dealt with labor market trends. We were passing around and discussing all kinds of forecasting materials that were generated by the Census Bureau and the Bureau of Labor Statistics when one employer stood up and said, “I'm confused. If you want to know where the jobs will be, why are you using all these secondary information sources? Ask me.”

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TEN BEST PROSPECTS . . . (numbers of jobs in thousands)

	1980	1990	+ or -
Secretaries	2,469	3,169	+700
Nurses' aides	1,175	1,682	+507
Janitors	2,751	3,253	+502
Sales clerks	2,880	3,359	+479
Cashiers	1,993	2,445	+452
Nurses	1,104	1,542	+438
Truck drivers	1,696	2,111	+415
Fast-food workers	806	1,206	+400
Clerks	2,395	2,772	+377
Waiters	1,711	2,072	+361

TEN WORST PROSPECTS

Postal clerks	316	310	-6
Clergy	296	287	-9
Shoe machine operators	65	54	-11
Compositors and typesetters	128	115	-13
Graduate assistants	132	108	-24
Servants	478	449	-29
College teachers	457	402	-55
High school teachers	1,237	1,064	-173
Farm laborers	1,175	940	-235
Farm operators	1,447	1,201	-246

Computer As Prosthesis

Douglas A. Fenderson, Ph.D.

A prosthesis is a device by which human function is aided or restored. Some 35 million Americans have a chronic limitation of function. Computers and computer-aided technology—a “one-in-several-centuries innovation”¹—promise increased function and independence. “Modern technology is capable of making the blind almost as if they could see, the deaf as they could hear and (the mobility impaired) as if they could walk ... but the gap between what is possible and what is likely will continue...”²

Children without language learn to communicate with computers. The problem may be developmental delay, lack of musculature for speech, affective disorder or other condition. But with skilled coaching, suitable programming and sometimes adapted controls, the demonstrated results have been remarkable.

Some children are so limited in physical control that breath (sip and puff) or eye-movement (reflected light, tracked by micro camera) is used. For these children, speed enhancement shows promise. The term “computer speak” has been used, to describe systems where a single input triggers a larger unit of communication. Adults with severe mobility limitations have used micro-circuitry

with breath, eye, or whatever muscles are available, to operate their wheelchairs, telephone, audio-video equipment, lights and appliances. Experiments with a micro controller joy stick suggest that persons with severe physical limitations may be able to operate personal licensed vehicles safely.

Deaf-blind individuals are now able to converse with others, using a portable keyboard to a braille communication device. This device provides telephonic access as well. Reading machines for use by blind persons have been around for some years, but the potential exists for a “next generation” of much more efficient print-to-voice machines.

Computer technology promises improvements in way-finding for blind persons, and hearing augmentation device for deaf and hard of hearing persons, but these areas await the further investigation of theoretical models.

Several computer companies provide training in computer programming for persons with severe sensory or motor impairments including blindness. Most of those selected for their interest and talent complete such programs and, within a few months, some of them earn much more salary than the counselor who arranged the

training.

Some disabled computer operators work at home. With a computer, disabled persons may have a “virtual office” wherever they happen to be. This provides great personal independence—a goal for many disabled persons.

To what extent can robotics help? This question is of interest to several federal agencies including the National Science Foundation, Veterans Administration, and the National Institute of Handicapped Research. One of the 17 NIHR-supported Rehabilitation Engineering Centers is currently conducting such experiments. A robot led the opening ceremony at the 1983 Rehabilitation Engineering Society of North America (RESNA), signaling serious interest by professional engineers. NIHR has received proposals also for adapting robots for personal care use.

Robotics is a sensitive issue on two grounds, however. There is the balance between personal control on the one hand and “depersonalization” or withdrawal of human-helping relationships on the other. Also of concern, is the possible stigma attached to the use of other-worldly-looking devices. This was dramatically illustrated by the unsuccessful attempts by mobility impaired persons

to use computer-controlled exoskeletal walking machines.

Scores of spectacular success stories notwithstanding, computers represent a threat as well. Technical barriers in mechanical design may impede the attachment of special input/output interface devices required by blind, deaf or severely physically disabled persons. New auditory or visual systems may exclude a significant group of potential users. And specific characteristics of operating systems and software may be incompatible with the use of "keyboard emulators" and other adaptive devices.

The National Institute of Handicapped Research (NIHR) is supporting, both through grants and contracts as well as collaborative and consultative efforts with private sector and other public agencies, a systematic approach to the elimination of these gaps and barriers.

On February 24, 1984, the White House Office of Private Sector Initiatives, in cooperation with NIHR, NASA, and the VA held a consultative conference with representatives of five leading computer manufacturing companies. The purpose of this consultation was to identify the kinds of problems disabled persons have in using standard computers, hardware and software, and to receive guidance on the resolution of these problems.

In her opening remarks, the Assistant Secretary for Special Education and Rehabilitative Services, Mrs. Madeleine Will, noted the increasing and pervasive use of computers for learning, vocation, personal achievement, and recreation. The information revolution holds promise of enhanced potential and fulfillment for millions of disabled persons, but, paradoxically, technical barriers in the mechanical design of equipment, and intrinsic limitations in operating sys-

tems and software may, in effect, perpetuate and increase the gap of disadvantage. Technical experts at the conference, speaking on behalf of disabled persons included conference chairman, James Reswick, Sc.D., Frank Bowe, Ph.D., Lawrence A. Scadden, Ph.D. and Greg C. Vanderheiden.

Bowe emphasized the fast-paced and highly competitive market as an impediment to corporate interest in computer adaptations for the disabled, but he summarized also demographic trends confirming the potential market for these devices. He noted that most "reasonable accommodations" at the design stage cost little. Finally, he noted the history of public access and accessible design legislation, and drew a comparison with the computer access problem, based on the significance of the information era to disabled persons, in all aspects of their lives.

Dr. Larry Scadden emphasized the "equality or irony" paradox posed by the computer revolution. Using his personal experience as a blind professional, he dramatically illustrated the high level of independence now available to him, together with the rapid obsolescence and limited application of the adaptive interface device he uses. He described the inherent vocational possibilities for disabled persons, and asked for a partnership of effort with leaders in the computer industry, to resolve the technical problems.

Vanderheiden emphasized the goal of universal access to standard computers and operating systems which accommodate, without costly revision, the special interface devices (keyboard emulation) and other technical alternatives, to eliminate or mitigate, in the design phase, the present serious problems of technical accessibility. He stressed that design

changes should be: (1) minimal and inexpensive; (2) where possible, increase the utility for all users; and (3) include multiple input and output ports and software "hooks" compatible with the range of individual adaptive software/hardware modules required by persons with various sensory or physical disabilities. Vanderheiden concluded by noting that not all the special needs of disabled persons can be met with simple accommodations, but that "a very large proportion . . . could be addressed with low- or no-cost changes. We believe that direct cooperation with companies developing new computer and operating systems will eliminate most barriers to computer access."³

Representatives of the computer companies indicated that the hardware problems (multiple, redundant input and output ports, for example) could be solved relatively easily. The problems with operating systems and software are more difficult. Most software, for example, is created by small private firms, not by computer manufacturers. It, therefore, tends to be less standardized in format, and often unique to a given device or application.

The representatives asked that *classes* of adaptive interface devices be identified, along with the limitations of functions they are designed to overcome. This will permit discussion of design specifications to resolve the interface obstacles. They also wanted a much more explicit statement of the ways in which such devices would require modifications of operating systems and software. They asked that groups like Vanderheiden's be identified to serve as a "reference bureau" with which to check design specifications or details of proposed design modifications.

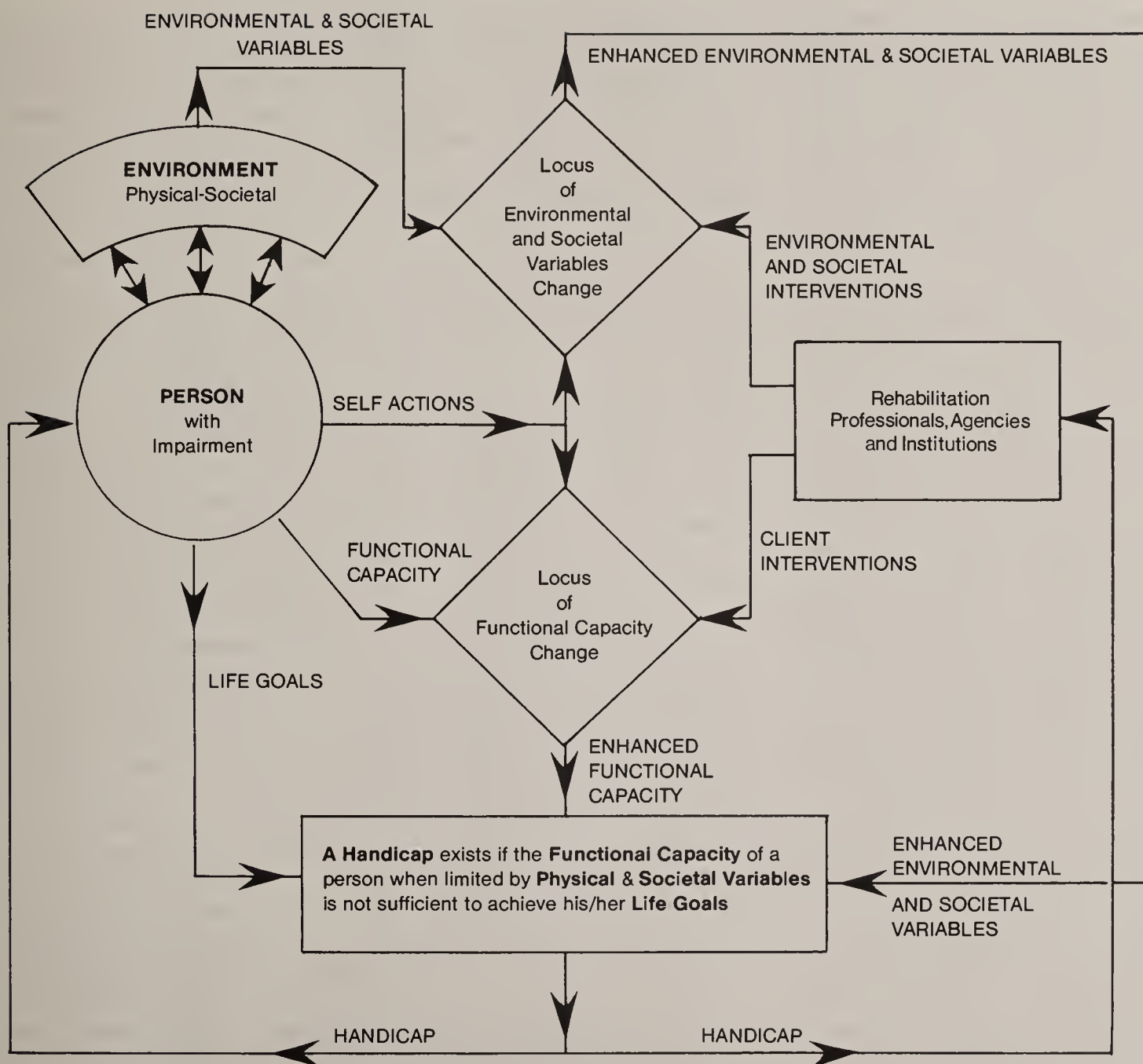


FIGURE 1
ELEMENTS AND ACTIONS IN REHABILITATION

Company representatives agreed to continue a consultative/collaborative process to resolve these problems. A representative of the Presidentially-appointed National Council on the Handicapped urged both company representatives and experts in applications for the disabled to remember that the real experts are the disabled persons themselves; and that the solutions should be proposed and tested in close collaboration with leading representatives of the disabled community.

As part of NIHR's systematic study of "Computers as Prosthesis", we have just completed a proposed five-year plan of rehabilitation research with the aid of a group of some 20 expert scientists and technologists. Our technology group has tried to anticipate studies which may materially aid disabled persons to overcome their functional limitations. A conceptual model (Fig. 1) by Dr. James Reswick was used as a basis for planning. As seen in this figure an impairment may cause a disability or limitation of function, which if an obstacle to achieving a personal goal in a particular environment, becomes a handicap. Resolution of the handicap may occur through self-actions or environmental changes.

A partial listing of the computer related technology goals included in our plan may be helpful to those who may wish to contribute to this exciting field. Many of the innovations represent the inspired work of technically competent lay persons who, often for some personal reason, have had to confront the reality of disability either in their family or neighborhood.

The NIHR Long Range Plan includes the following communicative devices:

A. For Blind and Visually Impaired Persons.

1. Electronic reading machines

with synthetic speech output emphasizing reduction in size, cost, and increased flexibility;

2. Data entry techniques using modern optical character recognition methods for production of Braille, speech, and digital forms for use by blind people;

3. High quality, low cost Braille embosser to permit both personal production of Braille material and rapid production of printed material for blind readers;

4. Improved mechanical, paperless Braille display devices using human factors engineering techniques, which emphasize simplified mechanical design, improved reliability, and low cost so that blind people can have mass storage and retrieval of printed material in Braille, either in single-line or full-page format;

5. Evaluation of existing speech output devices for use in conjunction with computer terminals with appropriate software or hardware, to enable the blind user to access the desired parts of the information displayed on the terminal;

6. Evaluation of the employment and vocational uses of interface terminals designed to meet the specific needs of blind people;

7. A portable, solid-state, closed-circuit television system for the reading of printed material by low vision individuals along with plans for distribution to consumers;

8. Techniques based on computer access and skills in the preparation of children for prevocational and vocational training.

B. For Deaf and Hard of Hearing:

1. New technologies that use micro-processor-based speech, preprocessing techniques, and innovative visual and tactual display techniques designed for deaf and hearing impaired persons;

2. Modern telecommunication

equipment for hearing impaired individuals to permit enhanced telephone communication and computer access;

3. Performance evaluation standards for hearing aids, and diagnostic and prescriptive hearing tests based on these standards;

4. Evaluation of emerging computer technology for practical adaptation of voice-to-print development for use by deaf persons;

C. For Language Impaired Persons:

1. Methods of interfacing communication aids for persons with different disabilities, considering the various types of spoken word, LED, and print devices designed to enhance two-way communication;

2. Study aphasic and other speech and language disabled preschool children to determine what devices (including computers) and technique foster improved speech;

3. Improved methods for providing access for severely physically handicapped persons to electronic devices, such as typewriters, computerized learning stations, synthesized voice machines, environmental control systems, and powered mobility.

D. For Mobility Impaired Persons:

1. Environmental control systems to allow persons to control temperature, lights, television, appliances, security systems, and other household instruments;

2. High technology solutions to aid in designing more accessible systems of transportation, including means to provide routing and scheduling information, safety measures, and physical access;

3. To establish safety and performance criteria both for equipment and the disabled driver, initiating shared projects and information exchange with appropriate federal, state, and local authorities responsible for regulating or enforcing safety and performance of drivers and

vehicles;

4. Investigation of blind pedestrians judged to be good travelers and development of a theory of blind mobility on which to base the design of new electronic travel aids;

5. Investigation of orientation systems, including systems for use both indoors and outdoors;

E. For Vocational Rehabilitation:

1. New approaches to meet the service needs of clients, such as computer-assisted instruction for social skills, job-seeking skills, technical job skills, and general remedial education;

2. Using computerized procedures to monitor and evaluate service delivery needs and availability of job openings for rehabilitation clients, making this data base available to overall program management by administrators and by case managers for making service delivery decisions.⁴

Computers are also advancing scientific study of quantitative aspects of disability such as "energy expenditure, limb position, limb loading,

walking speed, force vectors and muscle function in normal and abnormal walking . . .⁵ CAD/CAM is being applied to one-of-a-kind orthopedic footwear and related appliances. Micro-circuit controlled functional electrical stimulation devices (FES) have demonstrated potential to aid persons with paralyzed limbs to stand, exercise, and in some cases, walk. These devices also help control or correct spinal curvature as an alternative to bracing or surgery in some cases. They have been demonstrated to control self-injurious behavior in autistic persons, but because of the aversive stimulus, are controversial.

As memory aid, computers are being investigated for use with brain injured persons, and those with mental retardation. Applications to forgetful older persons have been suggested.

Future directions look promising. We see engineering and technology consultation becoming a routine part of the rehabilitation appraisal process. We see barriers to effective communication and engagement being

leveled through the power of the information revolution. We see disabled persons and interested friends using the power of their imaginations saying, "why not?"

Dr. Fenderson is Director, NIHR.

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High-Tech Not Complete Jobs Answer

Contrary to many expectations, the growth of high technology alone will not bring about a revitalization of the American economy nor resolve the nation's nagging problems with serious unemployment. The Bureau of Labor Statistics projects that high-tech development will account for only 7 percent of new job opportunities between 1980 and 1990.

Major job opportunities lie elsewhere. The service occupations—from fast food clerk to computer programmer—now account for 67 percent of the workforce. Since 1969, these occupations, BLS reports, have

accounted for nearly 90 percent of all new jobs.

Technological advancement, however, will have a dramatic effect on millions of jobs and workers in excess of the 7 percent of new jobs created. Separate estimates conclude that fully 55 percent of all workers in the immediate future will require a competent grasp of information technologies.

These technologies have an unprecedented ability to replace and supersede themselves, requiring at each new level of development an even more sophisticated comprehension of

their behavior. More trained people is one answer to capturing the potential of these technologies to improve American productivity. Another answer may lie in the training and retraining of workers at lower levels of sophistication.

The ultimate benefit to society and to economic development rests on the ability of American enterprise to develop commercial markets for these technologies, and to simplify and reduce what is complex and sophisticated into its less complex parts.

From: "Continuing Education and the American Workforce." A report of The National Advisory Council On Continuing Education. Sept. 30, 1983.

Do We Look To A Deus Ex Machina Or To An Index Card To Improve Placement?

Dennis J. Dunn, Ed.D

The following paper was presented on June 1, 1983 at the Region VII Placement Consortium Conference in Omaha. No attempt has been made to convert it from what was meant as an oral presentation to that of a magazine article. Dr. Dunn is Administrator of Program Planning for the Division of Rehabilitation Services, Nebraska Department of Education.

Deus ex machina. Literally "God from a machine." A device used in medieval miracle plays to get the characters out of a hopelessly complicated situation. At the right moment, a machine would descend onto the stage. God would step forth and work the miracle needed to enable good to triumph.

What is the future of job placement? Many of us would answer that question by first looking at the current state of vocational rehabilitation, as expressed in this quote: "Rehabilitation counseling is carried on in the context of a rapidly changing society. Two major opposing trends suggest that the labors imposed upon us demand Herculean efforts. On the one hand, such forces as technological change (automation especially), increased leisure time, and the decreased need for unskilled and semi-

skilled workers pose obstacles to rehabilitation which are difficult to overcome. On the other hand, society is placing realistic pressures on us to provide rehabilitation services to all who need them. Thus, we see increasing stress on the importance of rehabilitating the disabled public assistance recipient, OASI applicant, the penal offender, the narcotics addict, the alcoholic, the mentally ill, the school drop-outs, and many others previously considered too difficult to rehabilitate. Despite these conflict tendencies, it is both gratifying and inspiring that people in the rehabilitation field are not afraid to lock horns with destiny to meet the responsibilities charged to them . . . Circumstances and experience teach us that we are on the threshold of major breakthroughs . . . It is imperative that we keep abreast of new developments."

This sounds fresh, but it is not. It is from a presentation Reuben Margolin gave at the first Institute on Rehabilitation Services in May 1963. What makes it sound fresh is the basic belief that a major breakthrough is just around the corner—a *deus ex machina* to rescue us from the conflicting trends of a changing society.

There is a simple reason for our current, renewed interest in place-

ment. The time has come for us to talk about placement again. A new 7-year cycle of interest, concern, and activity about job placement is on us. Flannagan¹ first pointed out the cyclical nature of interest in job placement. He related it to the 7-year cycle of flourishing and decline in the ruffed grouse. Our fate is intertwined with that of the grouse. Grouse are flourishing as is our interest in placement.

If things run true to form, we will occupy ourselves during the next few years searching for a *deus ex machina*—a miraculous breakthrough to rescue us. Candidates for the role are already lining up: organizational development; marketing; employer advisory councils; and projects with industry. Others will come forward. Each candidate will get its backers. Some candidates will become fads and receive widespread attention. But when the grouse decline and our interest in placement fades, we will find that none of these turned out to be a *deus ex machina*: In fact, we will find ourselves doing placement in substantially the same way we do it today.

This will occur for a simple reason. The search for a *deus ex machina* causes us to lose sight of the main event—the placement of disabled

persons in suitable gainful employment. This is a practical result, achieved by technology. Technologies arise in response to practical problems. The passage of the Smith-Fess Act in 1920 created a practical problem: how do you "render a disabled individual fit to engage in a remunerative occupation?" A technology for solving this problem swiftly developed. By 1950 virtually all of the approaches, methods, and techniques we use today were on the scene. For example, Bridges² in 1946 described techniques for determining the requirements of jobs, appraising the abilities of disabled persons, matching abilities and requirements to determine suitability, and either modifying the individual or the job to achieve full compatibility. By 1950, Hamilton³ described functional assessment in some detail.

These basic techniques are summarized in several reviews.^{4 5 6} They are still the foundation of sound placement practice. Zadny and James⁷ subjected a core set of them to an empirical test by relating their use to placement outcomes and effectiveness. Overall, their results show that these techniques, most of which have been around for 35 years or more, lead to better outcomes.

Recent self-help books on getting a job are primarily a rebottling of old VR placement wine. Books by Bolles⁸, Lathrop^{9 10}, Jackson¹¹, and Jackson and Mayleas¹² focus on the main event—getting a job—and are uncluttered by irrelevant issues and procedures. More directly applicable to VR programs is the JIST program.^{13 14} This is a well-organized placement outcome oriented program which is surprisingly effective with chronic mentally ill individuals. Unfortunately, JIST is also uncluttered by diagnostic studies, eligibility determinators, and written individual-

ized programs making its implementation difficult in a state agency.

We obviously know a lot about how to place disabled persons and the technology needed to do it. At the same time, we know that technology is not fixed: It changes. Our conception of technological development is that it results from major breakthroughs. This, however, is not true. Significant advances are commonly the result of small evolutionary steps, not breakthroughs.¹⁵ Most of the time, the evolutionary step involves applying a relatively minor knowledge or technology from one field to a problem in another.

The information age we live in provides a convenient example of technological advance. Most of us attribute the switch from production of goods to the processing of information to the computer. In fact, the major technological innovation that made rapid information processing possible was the index card. Information processing requires you to store discrete bits of information, retrieve them, sort them, rearrange them, and link them to other information. These requirements are all met by the index card, which appeared in England during the late 1820's to the early 1830's, probably developed by a clerk trying to make his job easier. The idea that the computer could be used to process index cards came rather late. Computers were originally developed to solve large-scale mathematics problems involving iterations or simultaneous equations. The initial technological superiority of IBM in information processing applications stemmed from their cards, not their computers. The critical IBM patent was for rectangular holes in the cards. IBM cards contained more information and were less likely to jam.

In other words, we rarely find technological advances resulting from a

deus ex machina—a major breakthrough that resolves a critical problem. What is much more common are the small advances—the index cards and rectangular holes—that simplify processes and improve effectiveness and efficiency.

When we carefully examine our existing placement technology, we find that it is based on guidance and placement services provided by vocational rehabilitation counselors, not on particular staffing patterns, divisions of labor, or organizational structures. The latter are clutter that take our eyes off the main event, to use Elfrey's¹⁶ terms. The Zadny and James research, mentioned earlier, shows this. They looked at three innovations of the time: job seeking skills training, placement specialists, and supervisory-managerial performance of placement activities. Only job-seeking skills training has a significant positive effect on placement. Interestingly, during our last placement interest cycle this technique did not get much attention. The two candidates for the role of a *deus ex machina* were placement specialists^{17 18} and the "Michigan Model"¹⁹ in which all staff in the agency, including managers and supervisors, have direct, active placement responsibilities. Zadny and James found that the use of placement specialists increases the proportion of cases closed not rehabilitated but otherwise has a neutral effect. The supervisor-manager study, which unfortunately is not published, showed their activity has a significant negative effect on placement results. The more they are involved, the worse the results get.

Rather than searching for a *deus ex machina*, directing our efforts in improving placement technology to possibilities based on real world occurrences and behaviors, and searching

for index card technologies which can be readily implemented by counselors, is most likely to be productive. With this in mind, let us look at four possibilities, all of which have extensive empirical support. They are opportunity structures, organization entry and attachment, information networks, and job search.

Opportunity Structures

Rothstein²⁰ in a seminal review of the research findings on work career states: "Most individuals do not make stable occupational choices as the first step in their work careers, nor do they show a strong commitment to a particular occupation during their work careers. On the contrary, occupational mobility is far more characteristic of most work careers than occupational stability . . . As opportunities unfold during work careers, individuals use those opportunities to make future career and occupational choices. Thus, careers may be more accurately considered as a series of responses to a succession of opportunity situations than the effort to realize a predetermined occupational goal" (p. 328).

Rothstein observes that "... the nature of the opportunity structure is crucial to career mobility" (p. 340). The careers of most people occur within a specific organization where there is a mutual attachment between the worker and the organization. Rothstein says: "Workers should choose work organizations based on the opportunities provided as much as interest in the specific initial occupation. Work organizations differ widely in the opportunities they provide, because of their occupational mix, geographic location, and other factors, and these are usually more important to the worker than his initial occupation in the organization." (p. 341).

The applications of opportunity structure research to rehabilitation counseling and job placement of disabled persons are too numerous to go into in this article. I can mention three things we have done in the Nebraska Division of Rehabilitation Services. First, we conducted a Program and Administrative Review (PAR) of job placement activities and vocational outcomes in which we examined a cohort of active cases closed during February and March 1982. The findings clearly indicated the utility of the opportunity structure approach. In three quarters of the cases we reviewed, the outcome at closure could not be predicted from diagnostic study and original vocational objective. Instead, the outcome resulted from the counselor and client capitalizing on unpredictable opportunities that occurred as the case developed.

Second, we made a number of procedural changes based on the PAR findings. A major change puts emphasis on assessing the suitability of the outcome, while de-emphasizing the need to establish a highly specific vocational objective. In other words, we now say it is more important for staff to determine whether the unpredictable outcomes three-quarters of our clients achieve are actually suitable for them than it is for them to spend a lot of time developing specific vocational objectives that clients don't achieve.

Lastly, we are looking carefully at the nature of the employment opportunity structure in Nebraska. The first study showed significant discrepancies between the distributions of individuals and those of occupations on three basic measures (cognitive complexity, motor skills, and general educational development). These data indicate that as more and more people attempt to develop and maximize

their potential through education and training, they increase their probabilities of being significantly underemployed.²¹ A second study, just completed, indicates that two-thirds of the available employment in Nebraska fits into five clusters which are each reasonably homogeneous with respect to critical aptitudes, interests, adaptability, educational, training, and strength requirements.²²

The opportunity structure approach enables us to put the main event into focus. The central issue in rehabilitation is *not* identifying the occupation which is most consistent with client capacities, abilities, skills, and interests, or preparing the client for such an occupation. Rather the issue is how client capacities, abilities, skills and interests can be mobilized and enhanced to obtain employment within a constrained and continually changing opportunity structure.

Organizational Entry And Attachment

Wanous²³ recently pulled together much of the work done on organizational attachments, giving particular emphasis to the process of organizational entry. It is clear that in employee selection and hiring, the dominant concern of employers is in identification of "good employees"—individuals who will fit into the organization, stay with it, and make a productive contribution to it. In many hiring situations, particularly for entry positions which virtually anyone can do, the questions of organizational fit and stability are much more important to answer than that of productivity.

About 80 percent of work disability is the result of accidents, injuries, and diseases occurring in the working years, a fact we often overlook. Moreover, we commonly overlook the obvious implication of this: The

The initial technological superiority of IBM in information processing applications stemmed from their cards, not their computers. The critical IBM patent was for rectangular holes in the cards.

attitudes of employers toward disabled person are shaped primarily by direct, first-hand experiences with disabilities occurring among their employees. Data presented by Schrodell and Jacobsen²⁴ suggest that employer experience with various disability groups is comparable to that of state VR agencies: The groups which are least preferred by employers tend to be those with which VR agencies are least successful. We know the reasons VR tends to fail with these groups (such as alcoholics and mentally ill individuals) relate to the problems in individual stability, establishing and maintaining interpersonal relationships, and adapting to VR organizational rules and requirements (such as keeping appointments, punctuality, following instructions, and so on).

In other words, both VR staff and employers are reluctant to serve or hire members of some disability groups for the same basic reasons—adverse prior experiences in organizational entry and attachment. Employers, however, keep their eyes on the main event, screening out applicants who are likely to have organizational attachment problems. VR staff, on the other hand, look at productivity as the main event, and leave the organizational attachment problems untouched, either in treatment or post-placement followup.

Information Networks

Lathrop²⁵ describes the job market as an uncharted jungle for most people. The commodity traded in the job market is information, with most of

the trading occurring within existing information networks. These networks are imperfect: information travels slowly and people or firms aren't always plugged into the right network. At a national unemployment level of 10 percent, about 40 percent of all unemployment is "frictional" and can be attributed to problems in information networks—firms needing workers don't know about available workers and *vice versa*.

Granovetter^{26 27} describes the operation of these information networks, and the potential role of VR agency staff as information resources and brokers. There is no need to discuss it here, except to highlight the role of information networks in job creation. About one-third of Granovetter's²⁸ subjects were in created positions: ones which did not exist before the employer encountered the employee. Prior employer contact with a credible, trusted information source having personal knowledge of a potentially good employee appeared to produce created positions.

Job Search

We know that job seekers generally do not engage in an intensive, wide-ranging search for employment.^{29 30} There is a close interrelationship between activity and social networks on one hand and opportunities on the other. You come across opportunities if you happen to be in the right place or in contact with the right people at the right time. The more active you are and the larger your social network, the more likely this is.

Our placement Program and

Administrative Review pointed this out. We looked at the relationship between services and outcomes. For most clients the relationship was tangential at best. The benefits of services came from the increases in activity levels, changes in settings, and new friends that service participation required. In other words, it was service participation, not the services themselves, that produced results. Participation in on-the-job training, part-time employment, and work study, all of which require work activity in a work setting and relationships with workers, had the most positive effects.

Our review also indicated that placement was related to planning, monitoring, and psychologically supporting an intensive job search by the client. Effective counselors operate as if they are running a single-person Job Club. Job Clubs are effective,³³ but cannot be used everywhere.³⁴ Recent research by Azrin, Besalel, Wisoztek, McMorrow, and Bechtel³⁵ shows that behavioral supervision of the job search is the active ingredient in the Job Club. A new manual by Azrin and Besalel³⁶ lays out the preliminaries to an intensive job search in a format suited for self or mediated instruction. These new developments suggest that the positive effects of the Job Club can be achieved on an individual basis.

Conclusion

The four possibilities for technological advance discussed here can be implemented by any counselor who is bold enough to use them. There is no need to wait for organizations to develop, a marketing strategy to evolve, an employer advisory council to form, a project with industry to be funded, or some other *deus ex machina* to descend. There is precious little hard data to suggest that

altering organizational structures of inter-organizational relationships leads to improved placement outcomes. The main event in placement concerns the relationships individuals have with each other. The future is now for the counselor who understands this.

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From Independent Living
To Interdependent Living:

The Future For People With Severe Disabilities

Lex Frieden

Occasionally, difficult problems resulting from chaotic circumstances are resolved by unusual means. Reflecting on this type of situation, one of the main characters in a currently popular television drama, "The A-Team," often says, "I love it when a plan comes together—don't you?" Although it is entertaining to think that organization evolves naturally out of disorganized circumstances or that complex problems may be solved by spontaneous, fortuitous solutions, experience indicates that, in reality, lack of organization and planning generally results in further disorganization and more complicated problems. Thus, while some people are waiting on the future to see whether or not a plan comes together, other people are making plans in order to influence the future.

The future is a product of many forces. To a large extent, the future is shaped by the present. In fact, the present and all that has preceded it actually becomes the history of the future. Furthermore, the future is often shaped by predictions about the future. People seldom look for something that they don't expect to find. Finally, the future is shaped, to some degree, by systematic change which results from organized planning and plan implementation.

With respect to persons who are severely disabled, the future holds great promise. To the extent that the future is shaped by the present, disabled people are, for the most part, better off now than they have been at any time in history. Society has made great progress, especially during the past two decades, in coping with, adapting to, and accommodating people with severe disabilities. Technological progress has led to improvements in medical rehabilitation and restoration. Philosophical progress has led to both the normalization and independent living movements. Legislative progress has resulted in important acknowledgements of equality and civil rights for people with disabilities. If the trends in rehabilitation which are evident at the present time continue to project into the future at the same rate by which they have developed during the past two decades, the disabled population may be approaching parity with the nondisabled population in terms of lifestyle quality by the year 2000.

To the extent that the future is a function of predictions, there is also much for which to look forward. Predictions have been made about fantastic cures for certain conditions which result in disabilities. Predictions have been made about sophisticated com-

munication technologies which may reduce the deficits caused by sensory impairments. Predictions have been made about modernistic transportation systems which may reduce the deficits caused by mobility impairments. Predictions have been made about computerized teaching systems which may reduce the deficits caused by cognitive impairments. These predictions and others like them make one very anxious to reach the future.

To the extent that the future is a result of making and implementing plans, there is even more reason to be hopeful about the future. More than ever before, local groups are planning new programs to assist people with disabilities in their communities. Optimistic plans are being made by vocational rehabilitation agencies to place more severely disabled people into competitive employment. Plans are being made by independent living centers and by disabled entrepreneurs to start for-profit business enterprises. The National Council on the Handicapped has developed a plan to improve the quality of life and productivity of all people with disabilities in the United States. Some exceptionally constructive planning has been done for the future, and if these plans are well implemented, the future, again, appears very bright.

One may prognosticate about the future in general terms, or one may try to be more specific in an effort to provoke more serious contemplation of particular implications and ramifications. The following section of this paper represents an effort to be more specific about the future, particularly as it relates to severely disabled people and the independent living movement. Although it is more enjoyable to think of the future in terms of positive outcomes, some attempts will be made in the following section of this paper to look at the possible negative consequences of particular futuristic circumstances.

Independent Living

Independent living is, to some extent, a function of a person's attitudes about himself or herself. To another degree, independent living is a function of a person's environment, both social and physical. Because attitudes about oneself are related to the ways in which one is perceived by his or her peers and to the ways by which one can or cannot interact with his or her environment, the future will have significant impact on the way disabled people relate to the concept of independent living.

In many ways, the future is a product of change—change in the environment and change in the way people view themselves and the world around them.

As the United States moves from an industrial-based economy to an information-based economy,¹ there will be many more opportunities for the public at large to learn about disability. Improved communications and a growing conscientiousness about lifestyle quality will facilitate the process of information sharing as it relates to people's individual needs, desires, expectations, and abilities. In the future, many more people will

have an opportunity to learn about disability, its causes, and its consequences. Disabled people themselves will have more opportunity to express their needs and to propose solutions for their problems.

In 1977, the White House Conference on Handicapped Individuals provided a major national forum for the exchange of information by people with disabilities, service providers, and policymakers about problems faced by people with disabilities and possible solutions to those problems. The results of that information-sharing bonanza are still being felt by disabled people today, 7 years later. What if the resources and technology existed to enable the White House Conference on Handicapped Individuals to be an ongoing, dynamic forum for the exchange of ideas about disability related problems and for the proposition of constructive methods of eliminating barriers to independence and productivity by people with disabilities? By continually having a means of thoughtful interaction, disabled people, their advocates, and their supporters could effect progressive change more quickly, more broadly, and more assuredly. Consensus opinions on questions of priority and propriety could be achieved in a timely fashion, and innovative solutions to problems which are often lost or ignored today would much more likely be able to surface and be tested.

With computer networking by disabled people, rehabilitation agencies, and independent living centers, and with efforts presently being made to establish a national cable television network concerned with disability issues,² these futures are really not that far away.

The availability of appropriate information in a timely fashion will affect much more than people's atti-

tudes about themselves and others. In the future, vocational counselors will be able to locate particular jobs for people who have specific needs and abilities by searching computerized job listings all over a city, a state, or the nation. This will make the search for employment opportunities more efficient, more objective, and more effective. This type of information may also be effectively used to establish vocational opportunities prior to making decisions about training and educational goals.

In the future, disabled people and their family members who have suffered from a lack of information and a need for peer support may find this information and support available through a national network of interactive computer and televideo communications. People who once had to travel long distances to acquire certain information or to talk with other people who had similar problems and needs, and other people who have never had access to appropriate information or role models will be able to access information and exchange ideas with peers without sacrificing time and other valuable resources in order to overcome the barriers of geography and mobility.

Planners, architects, and builders in the future will make substantial improvements in the physical environment for people with disabilities, because they will have pertinent information automatically provided to them about design considerations, requirements, and demands which relate to physical accessibility by people with disabilities. Accurate information about accessibility needs, standards, legal requirements, and solution to design problems will be available when it can best be used. Oversights which frequently occur during the process of environmental change today will occur far less fre-

... the new age will lead to the manifestation of disability types which have generally been hidden or regarded as a normal aspect of our industrial based society.

quently in the future. Furthermore, as people begin to depend more and more upon remote forms of communication as opposed to face-to-face meetings for exchanging information, environmental and transportation barriers will become less and less evident and far less significant in the lives of severely disabled people.

As far as independent living programs themselves are concerned, it is likely that the number of programs will continue to grow. In the not too distant future, every disabled person may have direct access to an independent living program either by having one located in their own community or by remote connections with a program using advanced communications technologies. The programs themselves are likely to be viewed as focal points in their communities for information, service, and service referral for people who have specific disability related needs. Independent living programs are likely to maintain their strong consumer base and to depend upon consumer direction, and they will likely expand their consumer population and their constituencies by responding to the needs of disabled elderly people who continue to fall through the gaps of the existing human service structure and who are more and more beginning to relate to the independent living philosophy.

Independent living programs will also more than likely be among the first human service provider organizations to recognize and try to meet the needs of people with new types of

disabilities caused by the evolution of the information age. Although many of the barriers to independence for people who are considered to be severely disabled today will be ameliorated by the new emphasis on information and communications technology, the new age will lead to the manifestation of disability types which have generally been hidden or regarded as a normal aspect of our industrial based society. For example, many people with learning disabilities have managed to hide their disabilities and succeed in spite of them by finding careers and social roles which did not require them to manifest the symptoms of their disabilities. Now, just as the educational system is beginning to recognize and respond to the needs of people with learning disabilities, the information age is evolving and placing more demands on school systems to improve the basic reading and communications skills of all students. Because many of the jobs in the new era will depend on these skills, people who have difficulties in these areas will have fewer opportunities to "work around" their difficulties. In the future, anyone who has difficulty communicating will be

confronted with new types of barriers resulting from the information age.

Other new types of disabilities resulting from the information age will relate to changing patterns of socialization. Many people have spent much of their lives learning to relate to one another according to certain protocols of social behavior. With more people being able to do more things at home, and thus avoiding what is now regarded as normal socialization, the family unit will become much more important in the lives of all people. Some people will have difficulty adjusting to new demands for family interaction and interdependence. Other people will have difficulty adjusting to business and personal relationships which are conducted mostly through the aid of electronic media with little, if any, face-to-face contact. These adjustment problems may eventually be recognized as disabling conditions.

In the future, other new disabilities may result from increasing demands for man-machine interdependence. Robots will be programed to solve problems and to "think," in a manner of speaking. But, will they be programed to have "emotions," and, if they are, will those emotions make them compatible with their human coworkers, helpmates, and family members? Will a person whose robot suddenly fails and can no longer perform the household chores be disabled, or will it be his or her robot which is disabled? Independent living programs will more than likely be on the cutting edge of these sorts of di-

Will a person whose robot suddenly fails and can no longer perform the household chores be disabled, or will it be his or her robot which is disabled?

lemmas, providing supportive services both to the robot dependent human, and to the robot.

As one may conjecture from this bit of reality-based prognostication and imagination-based fantasy, the future will no doubt result in significant changes; changes which will more than likely create new opportunities for people who are regarded as being severely disabled today. In the future, some disabled people will no doubt be more independent, more productive, and perhaps much less handicapped than they are today. On the other hand, the same changes which affect some people in positive ways will no doubt have negative and as yet unknown impact on other people. While the future will reduce or eliminate barriers for some people, it will create barriers for others. Independent living programs and other rehabilitation programs must recognize this and be prepared to respond to changes in the future by developing new programs, and by planning effectively today to meet the changing demands of tomorrow.

Conclusions

The real strength of the independent living movement lies in its philosophy and its ability to promote empowerment by people with disabilities. While being historically sound, the independent living philosophy is also futuristically adaptable. People in the future will be frustrated by having a lack of options just as people with disabilities are frustrated today. People in the future will also be limited by the social roles which they are expected to play just as many people with disabilities are limited today. Finally, the desire to achieve a satisfying quality of life will be just as important in the future to the general population as it is to people with disabilities today. In the future, society's

measure of security and success may relate more to values of human sensitivity than to values of tangible assets and monetary wealth. The independent living movement is organized around relatively humanistic values today. Tomorrow, people with disabilities may be called upon to share their orientation toward these values with the rest of society.

Many people dislike change because change represents to them an unknown future. As a result, some of these people become victimized by changes in the future which they believe they cannot predict. On the other hand, some people are quite good at predicting the future based upon observations which they make and trends which they cite in the present. These people often maximize the opportunities which result from the process of change.

Because the future is to some degree shaped by one's expectations of and plans for it, it is probably in one's best advantage to plan for the future as one would hope it could be. However, to profit most by one's plans, those plans must be based on realistic expectations of the future. Additionally, since the future is more likely to be a product of many peoples' plans and expectations rather than those of just one person, it would seem valuable for disabled people and rehabilitation professionals to share ideas about the future of independent living in rehabilitation in order to reach some consensus about what the future really holds. It is hoped that this article and those which accompany it have laid a foundation for discussion by the rehabilitation community of the issues, problems, and opportunities to be encountered in the future. Rehabilitation consumers and professionals who plan for the future today will be responsible for shaping the future of

tomorrow.

One closing, hopeful thought about the future for people with disabilities should be noted. The independent living movement has thus far had a great impact on the way society relates to people with disabilities. Now, more than ever before, disabled people are meaningfully involved in the process of making plans and decisions which affect their lives. Disabled people have seized the opportunity to assume responsibility for their own lives, and to benefit proportionally from the risks they choose to take. Because disabled people themselves have taken the initiative to become involved in planning for the future with legislative bodies, public officials, rehabilitation and other human service providers, and with their own organizations, and because they know better than anyone else what is needed to maximize their independence and productivity in the future, much more progress in the area of independent living is likely to be made during the next step into the future than has been made during any equivalent step from the past. In the past, disabled people have been affected by change. In the future, they themselves will be the effectors of change.

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Internationally Tomorrow

Norman Acton

The global disablement situation in the year 2000 will be influenced by major trends affecting the fate of humanity as a whole, by the further evolution of our thinking about how to deal with the problems of disability and by the actions we take. Any predictions must be based on assumptions about what will happen in each of those areas during the coming 16 years.

These are forces in motion that may change the ways we think about disablement and break down the barriers that prevent the full participation of some people in the lives of their communities. As the components of human destiny evolve, they may tend to stimulate and support the progress we seek, but that is not certain. They may also interpose other challenges that people will find to be more demanding; they may generate issues related to disablement that are quite different from the ones we face or anticipate.

One fact seems to be certain. There will be a great many more impaired people in the world of 2000 than there are today. Estimates range to 700 million, compared to today's 500 million. And, with or without disaster, it is highly probable that the proportion of people with impairments will be higher than it is now. The relative certainty of these predictions will be understood from information to follow.

Since people affected by disability are a statistically important part of

every society—as many as 25 percent of the population when family members and others whose lives are touched are considered—their future is, of course, enmeshed in all developments that have an impact on the entire population.

The Trend Analysis Program of the American Council of Life Insurance has identified five potential crises facing humankind.¹ They are: the warming of the earth's atmosphere and its effects on weather, growing seasons, sea levels, and other essential conditions for the continuation of human civilization; the growing water shortage and its obvious implications; the collapse of the physical infrastructure (roads, bridges, railroads, water and sewage systems, dams, public buildings); the global financial crisis; and the threat of nuclear war. There is a real possibility that each of these, or all of them, will mature from potential to actual crises in the years between now and 2000. If that happens, both the physical and the social life of human beings will be subject to new strains and the plight of those who are already handicapped will be worsened. The attention and the resources of society that are required to improve our response to disablement will be diverted by these crises. In such circumstances, there is little reason to hope that significant improvement will occur in the human response to physical and mental disability. There is a distinct possibility that, in the worst combinations of

these crises, many gains already achieved would be lost as the resources of each family and community would be called forth for basic survival.

For the purposes of the present discussion, we will assume that humankind will somehow avoid the worst scenario implied by the above crises. Whether that will be accomplished by the evolution of new forms of social, economic and political action better suited to the realities of the world and its people or, as has been most of the human experience, by muddling through while a benign fate withholds the terminal blows, we will assume that it will happen and that human society will during the coming 16 years retain its capabilities to deal with the issues of disablement.

In the year 2000 the issues of disablement will not be the same as the ones we face today. They will be different because of three massive processes that are changing some of the fundamental qualities of human life, and because of the interaction between those processes and the modifications that may be expected to follow recent developments in the disablement field. We look first at the general, global processes.

Population Changes

The population of the world continues to increase by about 1.7 percent a year. It was more than 4.7 billion in June 1984, having grown by nearly one billion people since 1970. In the year 2000 there will no doubt be more than six billion people inhabiting the earth. Growth is most rapid in the least developed areas where poverty is widespread and the sources of impairment are many and prolific.

Old people will make up a much larger part of the year 2000 population. This is a consequence of improved health care and living condi-

tions that are available to parts of the population worldwide, and of the fact that in many countries the harvest of the post-World War II baby boom will be approaching elderly status at the end of the century.

A worldwide trend that could well be added to the crises cited above is the large-scale movement of people from rural areas and pursuits to the cities. The minor decentralization found in some industrialized countries is insignificant when compared to the frightening accumulations of poor and disorganized people in such urban areas as Mexico City, Sao Paulo, Lagos, Calcutta and Cairo. Demographic changes of this scope have many implications for the incidence and significance of impairment and also, when they continue for a generation, they begin to produce mutations in the natural behavior of people and in the workings of the social system.

The Proliferation Of New Technology

Every analysis of the future, or of the present for that matter, must take into account not only the incredible advances in technology, but also their rapid spread throughout the world. It is not difficult in East Africa today to find a Masai herdsman, striding along with cloak, staff and a Sony Walkman. Some 90 percent of the population of China now has access to television and the *China Daily* says that one out of four families in Beijing has a tape recorder.² These examples at the individual level are of course typical of what is happening in the world of work where we may anticipate that technological progress will make radical changes in the types of tasks that require performing, in the kinds of jobs that will be available, and in the education, training and physical and mental qualifica-

tions needed for them. Some current experiences, surely to be multiplied many times by the year 2000, include National Cash Register which cut its U.S. work force from 37,000 to 18,000 after introducing microelectronic parts, and General Motors which predicts that in 2000 its workforce will be 50 percent in the skilled categories compared with 16 percent in 1980.³

There is no doubt that the rapidly growing use of computers, robots and other devices will enable people with physical limitations to perform many more tasks, but that is only a part of the issue. Unless special steps are taken, people with impairments will be competing with many others who are equally qualified and equally in need of employment because of the changes in the job market brought about by the technological revolution. A higher proportion of available tasks will require nimbleness of thought and action and related intellectual qualifications, reducing thereby the proportion of jobs that can be performed by people with mental impairments. The net impact of the technological revolution cannot yet be forecast.

The Transformation of Social Processes

Futurist John Naisbitt had identified what he calls ten "megatrends" that are likely to transform life in human society.⁴ Space does not permit an analysis of the links between each of these and the issues we are discussing, but it is important to recognize that their composite consequences—especially those dealing with technology, the economy, decentralization of human institutions, the shift to self-help, the replacement of hierarchies by networking, and the opening of multiple options in peoples' lives—suggest

forms of social interaction that can have a profound impact on our success or failure in bringing about effective solutions to disability problems. Another "megatrend", the move from an industrial to an information society, adds another dimension to what we have said about the employment situation. As it becomes a worldwide phenomenon, it also heralds a much wider dissemination of the kinds of information and knowledge that are required in all stages of the campaign against disablement, from prevention and therapy to integration and full participation.

The two major unsolved problems in the disablement area are the prevention of impairment and the integration of those segments of society that are called disabled and those that are not. Both problems require a much more effective mobilization of public concern, social innovation, and political action than we have managed to date. If Naisbitt is right about the kinds of transformation we may anticipate, and if humankind manages in the course of those changes to introduce a more pragmatic approach to survival and the enrichment of life, we may hope for progress in both prevention and integration.

It is certain that those three powerful processes—population change, the proliferation of new technology, and transformations in our social machinery—will have impacts on each other and on the human experience that are far beyond the not inconsiderable adjustments they are already requiring. One would be rash to attempt to predict with any precision the situation they will have generated by the year 2000, or how their combined consequences will have interacted with other forces more specifically dedicated to the disablement question. Before any forecasts can be

attempted, it is necessary to examine the most important of those forces as they are being felt around the world.

The 1981 International Year of Disabled Persons achieved varying degrees of success and failure in various countries. From the global perspective, it may be said that IYDP did awaken interest in disability and increase awareness of the attendant problems. Of perhaps the greatest importance was that it called forth an accounting of what had been done to provide equal opportunities for disabled people and thereby stimulated additional action. In the industrialized countries and some capitols of the Third World, curb cuts, ramps, accessible transportation and other modifications of the physical environment have opened communities to people with mobility limitations. Sign interpretation, closed caption television, brailled and taped literature and documentation have given people with hearing and vision impairments new opportunities to engage in the information process that is more and more central to the operations of organizations and governments. At the same time, by both regulations and practice, more disabled people are to be met in the governmental, business, organizational, educational and social life of the community. The volume of participation is not yet anywhere near the ideal, but has increased.

Each of these improvements in the situation is important within itself, but their totality also has a larger and long-range value. It means that more members of the two segments of society, those called disabled and those not, are meeting in the context of the usual workings of society. They are gaining knowledge of each other and experience in interacting with each other. These are the basic requirements for progress towards genuine and natural integration. Combined

with the movement of more and better information about the realities of disablement, these developments have become parts of a chain reaction that will grow and envelop more and more people. Programs for education of impaired children in the regular schools, for employment of disabled workers in the usual workplaces of the community or in special shops with mixed personnel, and for integrated recreation all add to the frequency of the experience of each other which in turn will increase the facility of more contact. And so on, the chain reaction will gain momentum, reach more people, become difficult to stop.

Closely linked to that slow, but probably irreversible march towards a condition of natural integration, and emerging as a product of the combination of all the forces discussed above, will be a new and different way of thinking about disablement. The intellectual process in the direction of different concepts is already under way with new efforts to define impairment, disability and handicap, to understand them in functional terms as they affect people and families, and to place the concepts they represent in more realistic relationship with such ideas as dependency, the work ethic, and economic and social equity. This scholarly procedure will be accompanied and stimulated by the consequences of the phenomena discussed above: larger numbers and proportions of people whom we identify as being impaired; living conditions that will make everyone more aware of the presence of impairment and more pragmatic in response to it; radically new technological capabilities to cope with the limitations affecting some people; more and better information about causes and remedies; societies shaken loose from traditional stereotypes about people

and their roles in the community.

It is impossible at this stage to forecast all ramifications of this combination of thinking and experience by the year 2000, but it is difficult to imagine that, with the movement of minds already under way, the next 16 years will not lead to a greater maturity and realism about disablement than we have today.

It is difficult to be equally optimistic about probabilities in the areas in early stages of economic and social development. In general the same massive processes—population change, technological revolution and social reorganization—will affect them, but in different ways and at different paces. The forces we have described as pulling towards a better integration are only beginning in the many remote parts of these countries and, in view of the many other economic and political difficulties they face, it is not likely that movement will be rapid in the next sixteen years.

Before turning to conclusions, it is necessary to say a bit more about prevention. The assumptions made in this presentation about numbers of people and types of impairment in the year 2000 are that our efforts at prevention will not have produced significant improvement in the incidence of the major forms of impairment by that time. Why this pessimism?

An expert group of the World Health Organization has recently concluded that, in the industrialized countries, the most important causes of impairment and disability are chronic somatic diseases such as rheumatism, cardio-vascular pulmonary and psychiatric illnesses, genetically induced conditions, and chronic pain. Accidents and drug and alcohol abuse were recognized as factors of growing importance.⁵ We see conflicting reports about the reduction of

birth defects, but the best claims about other items in the list is that their impact is being deferred to a few years later in life. Here is ample evidence of the validity of the statement, "If we live long enough, each of us will eventually be disabled."

The same WHO group found that, in the developing countries, about 70 percent of all disability is caused by malnutrition, communicable diseases, low quality of prenatal care, and accidents.⁶ We must also recognize that the lassitude and inertia observed among people in poverty-stricken areas is often a product of malnutrition and endemic diseases and infections. Serious interference with both physical and mental development is often present with disabling consequences, although people so affected are rarely included in statistics about disablement. There are interesting initiatives to assist the improvement of the listed conditions which merit more attention than can be given here, but the inescapable conclusion is that there is no reason to anticipate that any of them will have moved to a level of activity that will reduce significantly the incidence of impairment by the year 2000. Unfortunately, a realistic appraisal should instead anticipate the possibility of significant increases as the numbers of people suffering from famine grow, as the use of automobiles and agricultural and industrial machinery spreads, and as the devastation of wars and civil strife continues.

Hence, the projection that in 2000 the proportion of "new" impairments will be at least as great as it is today, and the numbers of people with "old" impairments will grow steadily as more live longer.

If the processes described above continue, if the trends and forces we have identified remain at work, and if the assumptions we have made are

valid, what can we say about the nature of the global disablement situation in the year 2000?

First, we may anticipate that there will be more than 700 million people who are recognized as being impaired. This figure is derived by applying today's rule of thumb that at least 10 percent of any population is likely to suffer impairment to a world population in excess of six billion. That number is increased by the assumption that, with a new level of realism in our thinking, we will include not only the classic categories of conspicuous impairment, but also the millions who are affected by the other causes mentioned by the WHO expert group quoted above. It is further increased by a probable continuation of the trend to keep more and more people alive with impairments.

Second, the consequences of impairment will, for many, be different and less damaging than they are today, especially in the industrialized countries and in those areas of the Third World where progress is being made. These changes will be due in part to improved technology and methods for treatment, therapy, rehabilitation, mobility and daily living, and in part because of additional improvements in the physical and social environment. But, even more important, they will have come about because of the new and more realistic ways people will be thinking about impairment and disability.

In much of the world, the image of disabled people as a stigmatized fringe group will have lost its strength. The traditional stereotypes cannot survive the combination of contact experience and better information that we are assuming. This will all be a part of the process we have described as natural integration, and it is a healthy process. We must not, however, overlook the possibility

that new trends and new problems will emerge as a result. The impulses that have motivated society to respond to the problems of disability, however one may evaluate them, are not likely to serve as well in a different atmosphere of thinking and acting. New initiatives will always be needed.

Third, there will be in the year 2000, in the interrelated areas of employment and economic security, a great disarray affecting all people, including those who are called disabled. We have noted the influences to be expected from changes in the size, composition and location of the world's population, we have seen that the proliferation of new technology is leading to radical restructuring of the employment situation, and we understand that shifting patterns of social structure will affect the ways we think about and seek to resolve these issues. Estimates of the International Labour Office indicate that "in the industrialized North around 60 million jobs will have to be created between 1980 and the end of 1987 both to absorb those joining the workforce and to eliminate existing unemployment; but in the industrializing South nearly 600 million new jobs will be needed to give each member of the workforce an income adequate to meet his own minimum basic needs and those of his family."⁷ Extension of those data to the year 2000, and adding in the other factors we have discussed, makes it obvious that humankind is faced with a new set of problems the solutions to which are far beyond the scope of any existing plans. At the same time, evidence is gathering that social security and insurance systems are unable to meet the challenges of today, let alone the more serious ones predicted for the Twenty-first Century.

Questions of employment and of

economic security are of serious concern to disabled people and their families. While developments such as those listed above open new opportunities for people who are impaired, they also pose ominous threats. We will need new ways of thinking about work, economic security, and the roles of each in connection with the lives of disabled people and their families.

It would be rash to attempt to make any more precise forecasts about the global situation of disablement in the year 2000. The forces and processes at work, the trends to be observed, have characteristics with which we have had no experience. Their individual and collective impacts can produce circumstances of great advantage to people who are disabled. But there is at least an equal probability that they will lead to conditions of disadvantage. The greatest unknowns of all in these calculations are the will, determination and efficacy of the human response to these forces and processes, the use or misuse humankind will make of the trends.

Obviously, it will be advantageous if more attention is given to the scientific analysis of such factors as have been discussed, and to the preparation of plans to give opportunities for people to influence the future. At the world level, there are currently two comprehensive plans for the human response to disablement. The first is the Rehabilitation International Charter for the 80s, drafted through a world-wide process of consultation and adopted by the RI Assembly in 1980. The second is the World Program of Action Concerning Disabled Persons, adopted by the United Nations in 1982. Derived from the RI Charter for the 80s, it contains some shifts of emphasis and much more detail for governments and intergovernmental organizations. The

General Assembly has also proclaimed a Decade of Disabled Persons (1983-92) as a focal period for implementation of the World Program. Unfortunately, both of these documents repeat our historic mistake of drawing exclusively from the experience and the information of the past.

The Rehabilitation International Assembly has taken a step towards thinking about the future, directing that study of the organization's structure and work be carried out in the context of anticipated developments to the year 2000.

Until June of this year, Mr. Acton served as Secretary General, Rehabilitation International, New York City.

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Regional Rehabilitation Network Serves RSA Region IX

The Regional Rehabilitation Network (RRN) helps rehabilitation professionals and consumers in Region IX use *networking* (among themselves and with nationally-recognized experts) as a means of solving problems and implementing worthwhile new programs. Under a 5-year grant from the National Institute of Handicapped Research, RRN is presently establishing networks in two subject areas (more will come later in the project): *computer applications to improve rehab management and service delivery*, and *school-to-work transition programs*.

RRN responds to telephone calls or letters from throughout Region IX (California, Arizona, Nevada, Hawaii, and the Pacific Territories) with immediate, practical information—newsletters, print information, and technical assistance consultation when needed. Each person who wishes can then join a network of people who share an interest in new programs and practices on one of these subjects. RRN looks carefully at all innovations that are made part of the network, and emphasizes only those that have demonstrated evidence of success.

The project also is sponsoring two action conferences which will be held in late 1984. The Computer Applications Conference will feature recent developments in management information systems, computerized work evaluation and vocational assessment systems, and related efforts in other types of human service agencies, such as mental health. The School-to-

Work Transition Conference will bring together developers of exemplary cooperative programs and professionals in both rehabilitation and special education.

In *Megatrends*, John Naisbitt identifies networking as one of the principal forces that will shape our world for the rest of this century. The larger purpose of the Regional Rehabilitation Network is to find out how networking strategies can best be used in the rehabilitation field. RRN's staff, led by Project Director Dr. Thomas E. Backer, includes Dr. Edward M. Glaser (a leading authority in the field of knowledge transfer) and Dr. Carolyn L. Vash (former

chief deputy director of the California Department of Rehabilitation). In addition to helping Region IX professionals and consumers set up and operate the networks, RRN project staff is conducting research on the networking process itself.

A brochure describing the project, and a copy of RRN's *Directory of Networks in Rehabilitation* (it lists regional and national networking organizations that may be of help) are available by contacting: Ms. Betty Sanderson, Project Coordinator, RRN, Human Interaction Research Institute, 10889 Wilshire Boulevard, Suite 1120, Los Angeles, CA 90024. Telephone (213) 878-373.

presented at a symposium, "Communications Technology and the Elderly: Issues and Forecasts," held in the fall of 1981 in Cleveland, Ohio, and sponsored by the Center on Aging and Health and the Case Institute of Technology of Case Western Reserve University.

The Psychological and Social Impact of Physical Disability. Second Edition. Robert P. Marinelli, Ed.D., and Arthur E. Dell Orto, Ph.D., Editors. Springer Publishing Company, 200 Park Avenue South, New York, New York 10003. 399 pages. \$23.95

This book provides a comprehensive view of the problem of disability by combining the writings of more than 40 authors and presenting these works under the headings of: Perspective on Disability; Disability: The Child and the Family; The Personal Impact of Disability; The Interpersonal Impact of Disability; Attitudes Toward Disabled Persons; Sexuality and Disability; The Rights, Contributions, and Needs of Disabled Consumers; and Helping Persons with Disabilities.

Rehabilitation Psychology: Spring 1984. Quarterly. Vol. 29, No. 1, 1984. Special Issue on Program Evaluation. Robert J. Flynn, Editor. Springer Publishing Company, 200 Park Avenue South, New York, New York 10003. 64 pages. \$45/year, institutions. \$28/year, individuals. Single issues: \$8.

This volume includes the work of 11 authors under the following topics—Program Evaluation in Canadian Rehabilitation Facilities for Physically Disabled Persons: A National Survey; Rehabilitation Indicators and Program Evaluation; and Psychological Considerations Inherent in a Conceptual Model for Performance Appraisal of Human Service Professionals.

PUBLICATIONS & FILMS

Personal Computers And Special Needs. Frank Bowe, Ph.D., SYBEX, 2344 Sixth Street, Berkeley, CA 94710. \$9.95. Available in August 1984.

Computers may be the answer to more independent living for the disabled. This book shows how these machines can work many practical wonders for those confined to a bed or wheelchair.

The author is a nationally recognized authority on the use of microcomputers for the disabled and is a consultant for the U.S. Congress Office of Technology Assessment. Disabled himself, Bowe has a special interest in the problems faced by people with handicaps of all kinds.

His book shows how computers can be used to monitor security; control home appliances; summon emergency medical assistance; do banking and shopping; and much more. Bowe also discusses how computers can be used

to overcome difficulties with vision, hearing, mobility, and learning.

Also included is a buyer's guide to assist the novice in selecting the right computer for his or her needs.

Communications Technologies and Elderly: Issues and Forecasts. Ruth E. Dunkle, Ph.D., Marie E. Haug, Ph.D., and Marvin Rosenberg, Ph.D. Springer Publishing Company, 200 Park Avenue South, New York, New York 10003. 238 pages. \$31.

This book addresses two types of technology—devices to improve the hearing and sight of aged persons and mechanisms to link the elderly with health care delivery, marketing, and recreational systems. Newest developments in these fields comprise the technological portion of this book, along with issues of elderly needs, public acceptance, practitioner response, and cost-benefit. The volume consists of edited versions of papers

Language Used or Used Language?

Ron Bourgea

Some time ago, in an article (*Gaul*) in the *Washington Post*, Ellen Goodman defined a little war that could be termed the Franglais-Englench affair. In an article that called down Gaul's gall, for its attack on English words entering the French language, she suggests that our benevolence should cease and that we should retaliate against Englench by wearing underwear instead of *lingerie*, hiring cooks instead of *chefs*, buying bunches of flowers instead of *bouquets*, and cooking our tenderloins instead of *Chateaubriands*.

If they want to throw down the gauntlet, we shall have them run the gauntlet by mustering a counterattack: "If they want to ban Franglais, we will meet them at the beaches with boatloads of their own Englench. If they turn their drive-ins into *cineparcs*, we shall turn our *quiche* into cheese pie. If they no longer attend *le meeting*, we will no longer *rendezvous* . . . (but) if the French decide to give up and return to the old *laissez-faire* linguistics, well, they better not call it *detente*."

Superabundance. Sue these words for nonsupport.

Together. Be careful of the fellowship you give to this word, *i.e.*, while *standing* together may show a common resolve, *mix* together might puree us; *united* together may be a

disfiguring meld and would have been better expressed as *coming* together or *getting* together. If it is unity that wants expression, then the word itself already has enough togetherness. Whenever *together's* companion has the sense of joined or associated, the companionship is suspect.

"The agency released an audit report. . . ." An audit is an examination of accounts, but it also is "a final statement of accounts by auditors" (*Webster's New Word Dictionary of the American Language*). This sentence tells us adequately that we are dealing with the audit statement (not the process), so that report becomes extra baggage. We thought that that should be mentioned in our audit of this sentence.

"... effectively cope with . . ." "Cope" effectively copes by itself since, effectively, it connotes effectiveness.

Elongationitisism. The simple form is preferred.

He is capable of controlling his own care—he is capable of controlling his care. (His care *is* his own care! Use "own" only for super emphasis, as in, "It is his own case" in reply to a negative question or negative assertion.)

Comment favorably upon—applaud, commend, acquiesce, etc.; it is interesting to note that—interesting-

ly; had proven to be—was; the scientific community—scientists; in a useful way—usefully; a substantial number of—many; in many cases—often; under the auspices of—by.

Pastiche. Grab bags are great in junk sales; they have no place in precise writing.

Here is a letter by Mr. Bill Sullivan, as reproduced in *The Washington Star*:

When I was in college, shortly after the War of 1812, I sat at the feet of a lively professor of English, a man of different cloth. Rummaging the attic recently, I found sere and yellowed stacks of ancient notes I had taken in his enormously popular lecture course. Reviewing some of these, I ran across this gem which is at least semi-precious:



"Taking the long way home is desirable when you are courting and, if you get lucky, pleasurable. However, in communicating with your peers, brevity beats long-winded pomposity every time.

"Let me demonstrate. Describing a man as 'highly skilled and assiduous in anticipating or catering to the pleasures of others, a persistently aggressive intermediary, for his personal pecuniary gain, in the field of carnal pleasures' is clearly the long way home. Gentlemen, he's a pimp, that's what he is and never forget it! Class dismissed."

Would that our windy, double-talking government bureaucrats had sat at his feet!

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April-May-June 1985

AMERICAN REHABILITATION

- Job Coach
- Attendant Management
- Speech Products
- Summer Work



William J. Bennett, Secretary

On February 6, 1985, the U.S. Senate unanimously confirmed William J. Bennett as the third U.S. Secretary of Education. He had headed the National Endowment for the Humanities since December 1981. He was sworn into his new duties on the day of his confirmation.

The new Secretary did not waste a moment in both establishing his sense of humor nor his vision for American education. In a meeting with the press on February 11, he commented that the press had already characterized him as "round and rumpled," that he was "six feet tall and of medium frame," and that, in a sequence of articles, he was "41, 42, and 43" years old, each year compacted into a successive day's article!

In a set of five questions and five assertions, he outlined the critical areas in American education.

The questions were: "What should children learn? Where will good teachers come from? What is the quality of higher education? Do we have a common, and not exclusionary, culture? How do we keep the movement for educational reform in the hands of the people—elected officials, business, and community leaders and parents?"

His assertions were: "We must give more specific attention to the hiring and continuing education of principals, superintendents, chief state school officers — and for that matter, provosts, chancellors, and college presidents — but *especially* principals. Education is more than the attainment

of skills; it must also be the development of character. We must remember that educational improvement and educational excellence are goals for *all* students. We must remember that education is not a dismal science. In this period of renewal, we should resist both those who declare premature victory — those who say the problem is solved; as well as the cynics and the dampers, those who say, "You can't do anything, so what's the point?"

Each question and assertion was elaborated on. Dr. Bennett, that round and rumpled, six foot tall man of medium frame who is 41, 42, 43 years old seemed to have a clearer view of his philosophy than did the press of his physical circumstances!

Welcome, Dr. William J. Bennett.

AMERICAN REHABILITATION

Volume 11, Number 2

The weakest ink is better than the strongest memory.

Apr—May—Jun 1985

-
- | | | |
|---|---------------|---|
| 4 | The Job Coach | Paul Wehman, Ph.D., and
Richard Melia, Ph.D. |
|---|---------------|---|
-
- | | | |
|---|--|------------------------|
| 8 | Interaction Between Rehabilitation And Education | G. Earl Sanders, Ph.D. |
|---|--|------------------------|
-
- | | | |
|----|------------------------|-------------------|
| 13 | Employing The Disabled | Graham G. Goddard |
|----|------------------------|-------------------|
-
- | | | |
|----|--|---|
| 18 | Enhancing Attendant Management Skills of Disabled People | Gary R. Ulicny and
Michael L. Jones, Ph.D. |
|----|--|---|
-
- | | | |
|----|---|------------------|
| 21 | Speech Products Impact Rehabilitation Field | John M. Williams |
|----|---|------------------|
-
- | | | |
|----|--------------------------------|------------|
| 26 | Summer Work Experience Program | Judy Irwin |
|----|--------------------------------|------------|
-
- | | | |
|----|------------------------------------|------------|
| 29 | Review: Computers And The Disabled | Dale Brown |
|----|------------------------------------|------------|
-

DEPARTMENTS

- | | | | |
|----|---------------------|----|----------------------------|
| 2 | Topic of State | 24 | Report Resources |
| 14 | Language Used | 28 | New Publications |
| 16 | Notes On The Margin | 31 | News, Notes, Announcements |

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TOPIC OF STATE

Wisconsin Conference On Rural Rehab Challenges Attendees

"We must begin building competent and caring rural communities in Wisconsin if the needs and desires of people with disabilities are to be appropriately met," according to John O'Brien, keynote speaker at a conference sponsored by DVR, Rural Wisconsin, and the UW-Stout Program for Independent Living. O'Brien spoke to a crowd of 75 people from throughout the state attending the conference titled, "Building Caring Communities for People with Disabilities in Rural Wisconsin." O'Brien, an internationally recognized authority on mainstreaming people with disabilities, urged the creation of community support systems which included all community members in its activities and which regarded all people as assets, not liabilities.

"This conference is important because of Jimmy," declared O'Brien. "Jimmy is mentally retarded. He lives in a town of 3 to 4 thousand and had to leave his own town to get an education. His community had no place for him." O'Brien then added that, "this conference is also important because of Uncle Stanley. Uncle Stanley lost a leg to gangrene following a baler accident. He had to learn a whole new self-image as a person with a disability. Stanley's community had a part to play in defining his new image." O'Brien said that it was important to build caring communities that meet the needs of the Jimmys and Uncle Stanleys of the world—communities which preserve the integrity of people and

communities by resolving problems and conflicts creatively and locally. O'Brien added that an effective caring community develops all of its resources and confronts its own self-limiting beliefs and consequences.

To receive a special conference summary, contact: Rural Wisconsin, P.O. Box 7202, Madison, WI 53707.

—*DVR News*, Wisconsin Division of Vocational Rehabilitation, Madison.

Clients Present Themselves Via TV To Area Employers

Four Vocational Rehabilitation Clients (in Rhode Island), who are seeking employment, participated in Channel 12's Job Hunt. This program, aired weekdays from 6:55 to 7:00 p.m., gives individuals a chance to present their skills and employment goals to employers who may be watching.

The taped interviews, conducted by Ed Hart, began with an explanation of the Vocational Rehabilitation Agency's services by placement supervisor Patricia Ryherd. Each subsequent day was devoted to one individual's interview.

As a result of this exposure, the agency received several calls requesting information, referring individuals for services, and in one instance, requesting a job interview with one of the participants.

Vocational Rehabilitation expects to sponsor this show on a regular basis so that other interested clients will have the chance to use the media in their job hunt.

—*Rehabilitation in Rhode Island*, Vocational Rehabilitation, Providence.

Rehab/Salaries Noted In Arkansas

The (Arkansas) Rehabilitation Services closed. . . (its 1984) fiscal year. . . with 3,347 persons rehabilitated, many of them severely disabled.

Of those rehabilitated, 843 had orthopedic impairments, 450 were mentally retarded, 375 had mental disorders, and 282 were alcoholics.

Only 634 of the 3,347 were wage or salaried workers in the competitive labor market before rehabilitation. The number jumped to 2,412 after rehabilitation, while the total of unemployed students dropped from 223 before rehabilitation to just 4 after.

The weekly earnings of those rehabilitated came to approximately \$69,244 before rehabilitation as compared to an estimated \$447,576 after rehabilitation.

—*The Counselor*, Division of Rehabilitation Services, Little Rock.

South Carolina Rehabs Return Taxpayer Dollars

A recent study by the South Carolina Vocational Rehabilitation Department revealed an annual rate of return of investment in the program at 23 percent, with the department returning \$2.42 to the taxpayers for every dollar spent on the program.

Joe S. Dusenbury, Commissioner, presented the results of the study to members of the Budget and Control Board as he made a request for allocations to continue serving South Carolina's handicapped citizens to help prepare them for employment.

The study, according to Dusenbury, indicates that people coming through the program will increase their earnings by \$11.51 for every dollar invested in their service program. Their lifetime earnings may be expected to increase by an average of \$34,262 over the amount they would have received without such services.

This economic impact was revealed in a recent cost/benefit study of more than 7,500 handicapped people rehabilitated by the department during fiscal year 1983. Dusenbury explains, "the cost/benefit model used in this study is based upon systems of measuring service costs and financial gain developed at Rutgers University, the University of Minnesota, as well as other rehabilitation research centers. We tailored the survey to reflect costs and benefits for South Carolina residents."

—*New Horizons*, S.C. Vocational Rehabilitation Department, Columbia.

18-Wheeler Does Engineering Wheelies For VA's Disabled

The nation's first mobile rehabilitation engineering unit was unveiled at the state capital in Richmond, Virginia on February 5. Cutting the ribbon to the 18-wheel tractor-trailer was Governor Charles S. Robb and Madeleine Will, Assistant Secretary, U.S. Office of Special Education and Rehabilitative Services, Washington, D.C.

The unit, which is owned and operated by the Virginia Department of Rehabilitative Services (DRS), will travel throughout the Commonwealth delivering on-location engineering services to physically disabled people. Its primary focus is to help handicapped people enter the workforce by

modifying job sites, manufacturing adaptive equipment, and accommodating commercial health aids. Also, services look to the needs of educational and residential institutions as well as to the individual needs of homebound persons.

While DRS will continue engineering services from its inhouse laboratories in Norfolk and Fishersville, the unit will be able to assist business and people in other areas at approximately one-third its previous cost.

DRS Commissioner Altamont Dickerson, Jr., said that, in the past when someone needed assistance in a community away from a stationary laboratory, "many trips back and forth to the work location were required." This approach was "very time consuming and resulted in a costly investment of manpower which had to be passed along to the consumer, when feasible, or absorbed by DRS." By offering on-location services, he said, the department will reduce its expenditures and, simultaneously, provide more timely assistance.

At a cost approximately \$71,000, the unit was partially equipped by donations from private industries and businesses. It is expected to pay for itself in "direct" service fees in 3 years; and when you consider "indirect" benefits, Dickerson said, his department's investment will be returned during the 1st year of operation.

Indirect benefits, he explained, include such items as income taxes paid by disabled persons who are employed as a result of rehabilitation engineering technology and the reduction in medical payments which often occurs when rehabilitation engineering services are applied.

Dickerson said that, when appropriate, direct service fees will be charged by DRS for the unit's services; but no one, will be denied if private funds are not available.

Dickerson attributed the idea for the unit, as well as the development of the project, to his rehabilitation engineering staff at Woodrow Wilson Rehabilitation Center.

Project Success Bids Two-Year Extension

The Department of Administration (DOA) and the Wisconsin DVR. . . developed a 1-year project to improve rehabilitation services for state employees receiving Worker's Compensation.

Based on the project's success, it is being extended for 2 additional years. During the project's 1st year, 139 cases were reviewed, 94 cases referred to the DVR system, with 38 people returned to work. . . The results demonstrate benefits from early intervention and intensive reemployment rehabilitation servicing, according to Richard Kosmo, DVR program specialist.

At the start, DVR covered costs of outstate counselors and all costs DVR normally funds in Worker's Compensation cases. DOA funded the project, counselor's salary, and fringe benefits, and all costs for services DOA normally provides to Worker's Compensation recipients.

A project goal is to increase reemployment for selected industrially injured state employees. A job placement model involving early identification of industrially injured workers who have transferable skills which can be matched with civil service openings or job openings in the local labor market is used. The counselor screened cases about 2 weeks after the injury.

—*DVR News*, Wisconsin Division of Vocational Rehabilitation.

The Job Coach: Function In Transitional and Supported Employment

Paul Wehman, Ph.D., and Richard Melia, Ph.D.

Despite the increased attention given to job placement in recent years,¹ there are still thousands of severely disabled people who are unable to independently seek or hold a job. In fact, the U.S. Commission on Civil Rights² indicates that 50 to 75 percent of all disabled people are unemployed.

Many people with significant mental retardation, for example, need specialized training and other assistance in job placement, job site training, and long term support. Without it, they would not be able to be employed in real jobs.³ People with serious physical disabilities can also benefit by having an onsite job coach to provide guidance and support. Usually this population requires less by way of skill training and more by way of advocacy and orientation.⁴ This approach may be valuable with severely psychiatrically impaired people as well.

Job coaches have been used in transitional employment rehabilitation programs, principally by Projects With Industry programs.⁵ A job coach

can be defined as: "... a professional or possibly paraprofessional who provides individualized one-to-one assistance to the client in job placement, travel training, skill training at the job site, ongoing assessment and long term assessment; the job coach is expected to reduce his or her presence at the job site over time as the client becomes better adjusted and more independent at the job."

As more vocational programs begin to serve people who have been traditionally excluded from employment services on the grounds that they were "not ready" or "too low functioning," job coaches should become more numerous. This article describes the roles of a job coach in employment programs for persons transitioning from workshops, adult activity centers, nonprofit placement programs, and schools.

The Role Of The Job Coach

The job coach provides a service for rehabilitation counselors to purchase

in the placement and long term competitive employment of severely disabled people who need specialized assistance at the job site. A job coach is community-based person who works out of nonprofit placement programs, traditional rehabilitation facilities, vocational-technical centers, or secondary special education programs. He performs multiple rehabilitative service roles, such as travel training, parent education, job-client match evaluation, onsite behavioral training, client counseling, and assessment. The next section highlights specific job coach functions.

A key aspect in his role then is the linkage between the rehabilitation counselor and the client, the parents, and the referring agency. In most programs which use job coaches, the client is hired immediately for a real job. Hence, the role of the job coach is very important, especially to the employer, since he fills an important gap in employment services for severely disabled clients who risk losing their job.

The successful job coach easily shifts gears. For example, one day it may be necessary to participate in meetings with referring counselors, employers, or other administrators; later in that day or through the balance of the week, he may be present at the job site, involved in skill training and counseling.

In programs where job coaches have been highly effective, the job coach is involved in day-to-day training. The employer, clients, counselors, and parents all have confidence in the service the job coach provides; in order to establish this confidence, however, regular job site involvement is crucial. As the client becomes more and more capable, however, it is essential to reduce the amount of time at the job site—a concept known as “fading.”

Functions Of The Job Coach

Job coaches help severely disabled people achieve competitive employment through individualized planning involving the disabled person and his parents, employer, coworkers, rehabilitation counselor, and other services providers. The job coach provides direct service; the other people with whom he works, to a very large extent, determine the functions which he performs. For the severely disabled persons, the job coach is the advocate and primary job trainer. The job coach goes with the client to job interviews, helps fill out applications, communicates the client's abilities, and smooths the client's entry into the job. Once a client is hired, the coach works side-by-side with the client. He analyzes the job, breaks tasks into manageable components, and uses the least intrusive methods possible to help the client master skills and increase productivity. Because the persons needing the help of job coaches often have not worked before, the job

coach may perform a significant portion of the client's work until satisfactory performance is achieved. As the client is able to handle the job, the coach gradually fades away, until a minimum level of contact is reached. During this period of job training, assistance in arranging transportation or other activities of daily living may also be required.

From the point of view of the parents of the severely disabled person, the job coach is the person responsible for the successful transition to work for their daughter or son. Initially, the job coach must enlist parental support and confidence. He does this by identifying parent concerns, such as potential loss of income benefits, disbelief that their son or daughter can be a productive worker, or fears about the work environment. Information sharing and ongoing communication must be used to win parent confidence and keep it. This function may be a joint one shared with a rehabilitation counselor and teacher.

Employers are hesitant about employing severely disabled people, unsure about how to promote worker interaction on the job, and in need of “hands-on” techniques to adapt jobs and accommodate severely disabled workers. The job coach must respond to these employer needs by describing the direct service support to be provided in training the employee, describing incentives such as the Targeted Job Tax Credit, and providing employer-to-employer reinforcement. Verbal coaching and supervisor training can help overcome concerns of the disabled person's immediate supervisor. Increasingly, cost effective, reasonable accommodations are emerging to adapt jobs to match worker functional capacities. The job coach can serve as the employer's link to such accommodations. Coworkers interact with job coaches in many ways.

Job coaches introduce the disabled worker and model appropriate interactions. Being sure to respect the client's privacy, job coaches inform coworkers of reasonable guidelines and expectations of the client's job-related behaviors. Helping the client integrate socially into the workplace can be a truly important function.

The job coach often has a service vendor to service purchaser relationship to rehabilitation counselors. As a vendor of training services, the job coach must interact in a timely and open manner with the rehabilitation counselor. At the start of a referral, the relationship involves a joint review of the appropriateness of the referral and the specific intermediate and long term objectives to be achieved for the client. The job coach can be very helpful to the counselor in framing these elements, for it will be the job coach who provides the direct services. The counselor is ultimately responsible, however, for the client's individualized written rehabilitation program. The job coach must be an effective vehicle through which the rehabilitation counselor can provide vocational services to people who otherwise would not be in the labor force.⁶

The job coach's relationship to other service providers will vary, depending on the needs of the client, the geographic and social setting in which the assistance is provided, and the nature of the other services in the community. A client's group home leader might be invited to visit the job site and learn first hand the work which is performed. The job coach may visit the group home. Staff who provided prevocational or special education services to the client might be sent feedback on the person's progress at work to help them in working with other people and to benefit from their first-hand knowledge of the worker. Income benefit needs, medical service

For Further Information

To obtain the recommendations of the Harold Russell Associates Study, write:

Richard P. Melia, Ph.D.
National Institute of Handicapped Research
Office of Special Education and Rehabilitative Services
U.S. Department of Education
Mail Stop 2305
Washington, D.C. 20202

To obtain a Fact Sheet listing the "Role of Job Coach in Promoting Competitive Employment" and a schematic Figure illustrating paths of direct influence and indirect influence in the role of the job coach, write:

Paul Wehman, Ph.D.
Rehabilitation Research and Training Center
Virginia Commonwealth University
1314 W. Main Street
Richmond, VA 23284-001

needs, transportation problems, and related topics will at times require a job coach's attention. Information on related programs is a required tool for all job coaches.

Training Job Coaches: Issues And Opportunities

At present, most job coaches are trained for the functions outlined above in short term internship or practicum experiences at transitional or supported employment demonstration sites. The Specialized Training Programs at the University of Oregon, Eugene, under the leadership of G. Thomas Bellamy, Ph.D., and the Rehabilitation Research and Training Program at Virginia Commonwealth University, have programs that train people as job coaches. These programs also have developed technical assistance programs, audio-visual materials, training manuals, and position descriptions for administrators and direct service providers, to increase the competencies of people providing assistance at job sites for severely dis-

abled workers. (See box.)

Job coaches have also been trained by inservice efforts of transitional employment or Projects With Industry programs. The Fountain House program in New York City has trained hundreds of people to organize services using the "club house" model of transitional employment services for chronically mentally ill persons.

These training efforts have developed in relative isolation from other rehabilitation training programs. They have largely been the by-product of necessary staff development efforts of the innovative direct service programs. Most rehabilitation training programs have a standardized curriculum and admission criteria and graduate "professionals" with a certificate or degree in hand. Existing job coach training programs emphasize pragmatic acquisition of specific skills and supervised performance until fully trained status is achieved.

This approach has worked well in demonstration sites. But, the number of people to be trained was limited,

and the trainers were the innovators and originators of job coaching methods. Participation in the courses was controlled by a process of word-of-mouth referrals. Close linkages of trainers and service settings provided the necessary ongoing supervision and performance evaluation in the follow-up period. In a nut shell, as long as the numbers involved were small and the training circumstances tightly organized, great results were achieved.

The Office of Special Education and Rehabilitative Services (OSERS) examined transitional employment services supported employment outcomes as part of an overall initiative established by Assistant Secretary Madeleine Will in 1983. In the process of establishing OSERS objectives for school-to-work transition, the positive contributions of "job coaches" in providing services in competitive employment settings were identified. As OSERS plans became more specific, strategies for funding grants and contracts for additional transitional and supported employment programs emerged. The issue arose of how to staff such programs adequately.⁷ Consultation with leaders in the fields of rehabilitation, special education, developmental disabilities, and mental health, as well as advice from parents groups and consumers, indicated that attention should be given to training direct staff for these emerging models of employment preparation and support.

In February 1985, the National Institute of Handicapped Research awarded a contract to Harold Russell Associates, Inc., of Waltham, Massachusetts, for a study titled, *Development of Staff Roles for Supported and Transitional Employment Programs*. Its purpose is to define and address the critical organizational characteristics of supported and transitional employment programs, namely, the role and responsibilities of job coaches and ad-

vocates. Experts in this area will be charged with the responsibility of defining those roles through a consensus-seeking process.⁸ The results of the study will be carefully considered in framing future training programs and related efforts.

Conclusion

The emergence of the job coach need not be a threat to any rehabilitation profession. Job coaches offer the possibility of providing direct assistance heretofore often unavailable. Such help can make the difference as to whether a severely disabled worker who has difficulty learning and transferring tasks or adjusting to a work site will enter and succeed in the labor force. Job coaches at present are not credentialed rehabilitation professionals. They are people who have excellent competencies in some very specific vocational and behavioral skills which they apply expertly for the assistance needed by severely disabled workers.

As the demand grows for people performing such roles, major issues must be resolved. Training strategies must be devised. Methods of listing and determining competencies must be identified. There will be increased need for supervision of job coaching. Rehabilitation counselors will need to learn of job coaches and how best to use and evaluate their services. Other issues involving job coaching and educational settings, employer concerns, career-paths for job coaches, payment and benefits, and other administrative factors will emerge.

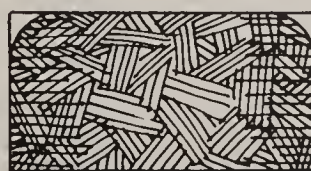
Ongoing discussion of these issues in the study by Harold Russell Associates, at professional meetings of rehabilitation groups, among parent and advocate groups, by employers and demonstration programs, and in many additional settings will help resolve these questions. One point seems

quite certain, however: *Job coaches are here!*

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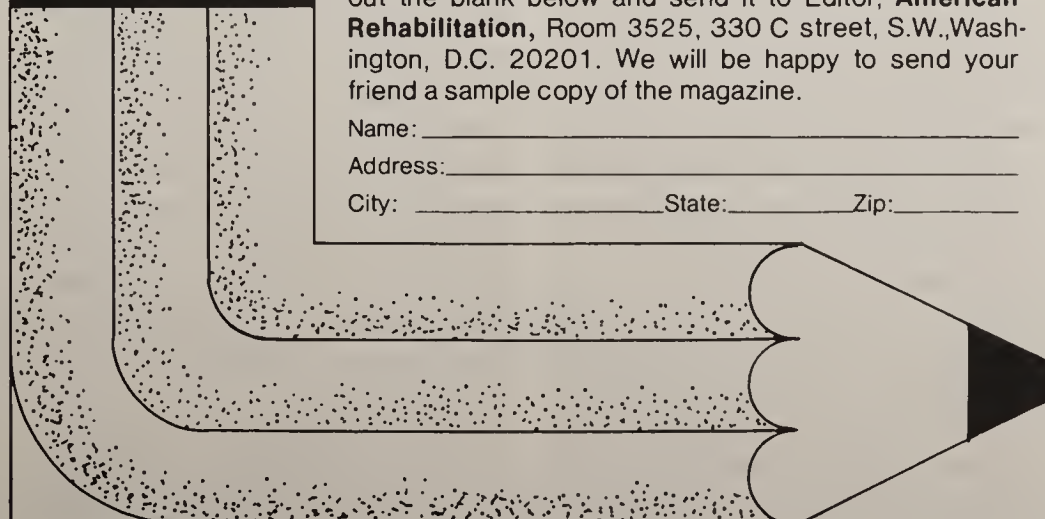
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Interaction Between Rehabilitation And Education:

The National Leadership Training Program Experience

G. Earl Sanders

The 1983 "Entre Amis" Conference on deaf education in Winnipeg, Canada,¹ featured one strand on joint rehabilitation-education efforts. The number of presentations made on this theme were few. Nevertheless, the fact that a strand was offered underscores the perceived need for improved cooperation between the two agencies which exercise such enormous influence in the lives of deaf individuals all over America. The need for cooperation has been highlighted by the rubella epidemic children of 1964-1965, many of whom have multiple-handicapping conditions and who are now in the transition stage between educational programs, rehabilitation services, and independent living.

The purpose of this essay is to briefly review the record of rehabilitation-education cooperation in the field of deafness, to explain the experience of the National Leadership Training Program in the Area of the Deaf (NLTP) as a cooperative

rehabilitation-education effort, and to offer several suggestions for improving the working relationship between these two public agencies.

Background

Cooperation between rehabilitation and education in deafness reaches back more than 25 years. Deaf education by the early 1960's has served the deaf community for almost 150 years and possessed a distinguished history as the primary, indeed, almost solitary, public agency concerned with the deaf person. In comparison, rehabilitation was a relative newcomer in serving the deaf person by the late 1950's and early 1960's. Nevertheless, the Babbidge Report of 1965 noted that, by the early 1960's, rehabilitation counselors were already placed and functioning at some residential school campuses.²

The decade of the 1960's witnessed a great many changes and opportunities for the deaf community and for

agencies which served it. There was an availability of money and a willingness, especially by federal programs, to use it for innovative efforts to serve the disabled. In order to capitalize upon these opportunities and to encourage more effective cooperation between rehabilitation and deaf education, the first "Las Cruces" Conference was convened in 1967.³ The specific purpose of the meeting was to develop "effective working relationships at the state and local levels," to be accomplished by bringing together national leaders in the field of deafness from rehabilitation agencies, educational programs, and leaders of the deaf community.

A major point of consensus arose from the first Las Cruces Conference: "Constantly being urged was that the educators of the deaf and rehabilitation people must get to know more about each other's field. Perceptive awareness of the responsibilities, methods of operation, potentialities,

problems, limitations imposed by statute or practices; these and other details of the two fields would work to define areas of cooperation calculated to bring results with least lost motion."⁴

Its prevailing philosophy was one of diffusion downward. That is, it was presumed that by establishing cooperative linkages among leaders at the national level, such relationships would be encouraged and nurtured successively downward through regional, state, and local areas. To this end, regional counterparts of the national conference were convened throughout the United States in the late 1960's and early 1970's.

In 1976, a second national conference met in Las Cruces.⁵ The thrust of this meeting differed somewhat from its predecessor. While conceived as an opportunity to reconsider and renew the concepts agreed to in 1957, it was also envisioned as a vehicle to provide evaluation and, more importantly, to explore prospects for future advances. The coordination of efforts between education and rehabilitation thus represented only one of many needs considered.

Subsequent to these watershed meetings of professionals serving in the field of deafness, there have been other initiatives to more closely integrate the efforts of rehabilitation and education agencies. Congressional lawmakers felt strongly enough about coordination of efforts that the 1978 Amendments to the Rehabilitation Act of 1973 contain this provision: "The State plan must also assure that specific arrangements are made for the coordination of services for any individual who is eligible for vocational rehabilitation services and is also eligible for services under Part B of the Education of Handicapped Children Act of the Vocational Act."⁶

The 1982 annual report of the Na-

tional Council of the Handicapped also recommended better coordination between special education programs and vocational rehabilitation programs, even suggesting the development of an Individualized Career Plan (ICDP), which would be based on the Individualized Education Plan (IEP) and the Individualized Written Rehabilitation Plan (IWRP).⁷

There is evidence that state-federal rehabilitation is making an increased effort to improve cooperation between itself and educational agencies (historically, it appears that rehabilitation agencies exhibit greater concern for cooperation than educational programs). The joint development of the IEP/IWRP has been offered as one possible vehicle for strengthening cooperation. A report issued as a result of a *Model of Exemplary Practices in Coordination Special Education and Vocational Rehabilitation Services* describes a number of projects nationwide that are exemplary, some of which include hearing-impaired students.⁸

Historically, the pattern for enhanced coordination of education and rehabilitation has resulted from initiatives at the "top," primarily by national agencies and leaders. The anticipation is that momentum generated at the highest levels will eventually filter downward for implementation at the local level. The combining of Special Education Programs and the Rehabilitation Services Administration within the U.S. Department of Education is a step closer in creating national integration of these agencies.

There are, and continue to develop, notable successes in such cooperative efforts at many levels. However, there has yet to appear a consistent, long term pattern of cooperation at any level, most importantly at the grassroots level. Local successes historically derive mainly from the inde-

pendent efforts of one or several people. Such endeavors usually do not become institutionalized or permanent, but tend to disappear when the persons who created and sponsored them move to other responsibilities, lose their capability to support the project, or burn-out.

Problems which seem to hinder the development of closer coordination between rehabilitation and education seem to be three: organizational, funding, and attitudinal.

In most states, there are no real organizational ties connecting agencies serving disabled children and adults. Using California as one example, educational programs are regulated through the State Department of Education. The State Department of Rehabilitation, on the other hand, is housed within the more general Department of Health and Welfare. This is not unusual: Rehabilitation services are offered in fewer than 10 states through the department of education. Most states place rehabilitation in departments of special services, health and human services, human resources, labor, etc.

There are, as a result, obvious organizational separations between local programs and agencies providing rehabilitation and educational services, reflecting the program separation at the state level.

In the early 1960's, when deaf education mainly occurred on residential school campuses, the prospects of combining efforts could be fairly simply achieved by placing a rehabilitation counselor on the school campus. With the tremendous changes that have taken place in deaf education in the last 20 years (the bulk of deaf children are now educated in a complex variety of public day school programs), such a clean-cut achievement of cross-organizational cooperation as placement of an RCDT (rehabilita-

tion counselor for the deaf) in day school programs is rarely possible.⁹

Funding can compensate to an extent for a number of problems. The problem of separation between deaf education and rehabilitation has been recognized for many years. Funds from the federal government supported the Las Cruces Conference of 1967 and 1976, as well as the regional conferences of the late 1960's and early 1970's. Federal money also helped initiate the Council of Organizations Serving the Deaf (COSD) in the early 1970s. However, when federal funds dried up, this last organization, which included national education and rehabilitation programs folded operations. The COSD continues on a statewide or local basis in a number of areas—in August 1984, Mississippi celebrated its seventh annual meeting, for example. Nevertheless, the Council of Organizations Serving the Deaf concept nationally could not be sustained without federal funds.

Special funding, most often from rehabilitation sources, has financed local cooperative efforts between rehabilitation and educational programs. However, the normal intent of such funding is short term. Long term or permanent ventures, especially in a period of depressed spending, have not materialized.

Attitude may be as significant, and potentially is more critical, as a problem than organization and resources. Suffice it to note that attitude for the purposes of this essay not only includes the feelings of professionals in a field (either rehabilitation or education) towards the other field, but also includes the knowledge and conceptions possessed by the individual which shaped those attitudes. This problem will be explored in greater detail in the section below relating to the National Leadership Training Program.

National Leadership Training Program

The National Leadership Training Program in the Area of the Deaf (NLTP) is a Master's Degree program located at California State University, Northridge, designed to train administrators in the professional field of deafness. The program has been funded since 1962 by the Rehabilitation Services Administration, with recent funding joining it from the Division of Personnel Preparation (Special Education Programs). The original—and continuing—purpose of the program was to bring together professional personnel from rehabilitation and education and to train them in helping resolve the lifelong problems of the deaf people. The first proposal to fund the NLTP stated: "There is a need to develop a corps of leaders who understand and can work with groups and agencies concerned with the problems of the deaf from *infancy to adulthood*". This has remained an essential program component since the very beginning.

Since 1962, the NLTP has graduated over 300 trainees (with approximately 100 hearing-impaired graduates and 200 hearing graduates). Trainees have attended the program as experienced professionals not only from community services agencies and business and industry. Trainees represent some of the best qualified people in their respective fields (approximately one in every five applicants is admitted to the program annually).

A review of selected former and current trainees was conducted to ascertain the extent to which educators possessed knowledge of the purpose and process of rehabilitation (prior to training). A similar inquiry was posed to trainees entering the NLTP from rehabilitation, concerning their acquaintance with the nature and problems of the educational process.

In only rare cases have the NLTP trainees had an indepth knowledge of both the fields of rehabilitation and education. A minority of trainees (about 25 percent) possess some familiarity with the other field. However, in approximately 75 percent of cases, trainees had a negligible knowledge of the other field. More serious, professionals from both fields often possess incorrect, and sometimes negative, views of the other field.

Trainees on the rehabilitation side more frequently tend to bring into the NLTP a jaundiced perspective of deaf education and of their educator counterparts. They are exceptionally concerned about the number of deaf children who become "failures" of the educational process, and they are inclined to blame schools for inadequately preparing the students. They feel that rehabilitation becomes a dumping ground for the mistakes of the educational system. Educators, on the other hand, are frequently unaware of the character of a deaf person's life once he/she passes beyond the confines of the school setting (unless, of course, they are hearing impaired themselves). The horizons of many teachers are limited to the classroom; they are often ignorant of rehabilitation and community services agencies and the contribution the latter make to the deaf community.

Given these circumstances, initial contact in a closely integrated program is occasionally uncomfortable for many trainees. At first, trainees find it difficult to comprehend how work in the other agency has implications for their own field, and they struggle to understand the problems and dynamics of their colleagues from the other field.

Nevertheless, the philosophy of the NLTP is that the most effective leadership in deafness, whether rehabilitation, education, or another professional area, is that which best under-

stands and can plan for the lifelong problems of the deaf person. Participation in the National Leadership Training Program, therefore, exposes trainees to these experiences (and thus to the other field) in three ways: in classroom instruction; through fieldwork, internship, and special projects, and (often most influentially) by means of daily association with fellow trainees from the other field.

Trainees remain in the program for 7 intensive months. The result of instruction and interaction is, hopefully, a professional who not only comprehends the lifelong challenges of the deaf person, but who also appreciates the mutual, interrelated responsibility and opportunities shared by educational and rehabilitation agencies in helping deaf people reach their potential in education and vocation.

Because of their newly acquired understanding and colleagues from the other field, graduates of the National Leadership Training Program often experience a dramatic change in working attitudes and philosophy. To the educator, it is often most apparent in the perception of student success. One former teacher summed up his reaction by noting that, prior to his NLTP experience, student success was determined by the percentage of students who enrolled in Gallaudet College. Following NLTP (during which he shared an apartment with a rehabilitation counselor), he saw the greatest importance in development of job skills and vocational readiness.

The greatest change in attitude occurred with rehabilitation and other noneducational professionals. Training and their association with teachers helped them better appreciate the educational struggle of deaf children and the resultant problems it poses for later independent living and vocational preparation. Rehabilitation graduates become more firmly com-

mitted to developing and maintaining cooperative ties with educational programs, in order to facilitate the transition of deaf people from one system to the other and to independent living.

A secondary, but interesting, spin-off of NLTP training has been to stimulate a number of graduates to move into the other field. Thus far, approximately 20 graduates of the program have changed their career plans, with the larger proportion moving from educational roles into rehabilitation or community service endeavors.

Recommendations

It seems apparent that a number of factors hamper closer working ties between rehabilitation and educational services for deaf people, among them being organizational separation, scarcity of funding, and the attitudes of professionals serving in both fields.

Theoretically, it would make sense to recommend that all states restructure their bureaucracy to place rehabilitation services together with education. In this, the states would be following the lead of the federal government. While this indeed appears advisable, one must also keep in mind that education and rehabilitation are large, complex organizations, and the mere lumping of them together does not necessarily resolve basic problems. It seems safe to say that it would require a number of years for the two agencies to achieve a real unity of action.

Sufficient funding can often compensate for a multitude of problems. In this case, money could be (and has been) used to develop innovative programs of a joint nature between education and rehabilitation. Unfortunately, such funds are normally temporary, and projects often wither upon the withdrawal of special support. The publication of the report *A Nature at Risk*, and other indicators, suggests that increased emphasis on schools may gradually improve the fi-

nancial condition of the educational field. Nevertheless, the long term prospects of education and other human services areas remain tight, and it is unreasonable to presume that money will be available to build permanent programmatic ties between rehabilitation and education, especially if organizational ties remain informal.

It may be in the area of attitudes that the best prospects lie. If the experience of trainees of the National Leadership Training Program serves as any benchmark, professionals in both fields—those who directly influence the life for the deaf person—have only a modest knowledge of, and interaction with, their professional counterparts in the other field. This has obvious implications. The work of professionals, including many in leadership assignments, is compartmentalized and in isolation. The net result is to have the needs of deaf individuals compartmentalized. The consequent problems for the deaf person are well-known as they struggle to make the transition from the school to rehabilitation services, thence into independent living and employment.

The preservice training of professionals in both rehabilitation and education serves to offer the best opportunities of shaping the knowledge and attitudes of those entering the general field of deafness. A brief survey of teacher training (deaf education) and counselor training programs suggests that new trainees receive little information about the counterpart field. What information they receive is cursory.

A specific recommendation is to include at least one formal class in each course of study on programs and services outside the major area of study. As a supplement to this, students should be exposed to as wide a variety as is available in the area of agencies serving deaf people. Fieldwork can be employed as a device for becoming ac-

quainted with these services. In addition, opportunities to interact with deaf people of all ages should be built in as part of the additional process.

The author believes this is the most effective way to build greater cooperation between education and rehabilitation for deaf people. It will obviously require an expense, inasmuch as it will necessitate significant changes to the college training process. It will be especially challenging to modify the curricula of the deaf education programs, inasmuch as these are governed by credential requirements established by the states. Nonetheless, it may constitute a healthy step in the development of mutual understanding, which is a necessary step in cooperation between education and rehabilitation.

A second suggestion is for inservice training programs in both rehabilitation and education to be modified in scope and content to periodically incorporate information and materials relating to the other field. Where possible, it is further suggested that possible joint inservice activities be held periodically. This may run counter to tradition and to the overwhelming inservice needs unique to each agency. Nonetheless, it seems to be an investment that will pay dividends in better coordinated services for deaf people.

The third recommendation refers to professional organizations and their periodic meetings. In 1983, the convention of the combined organizations of the North American educators of the deaf took place in a separate city one week apart from the conference of the American Deafness and Rehabilitation Association (ADARA). Both conferences provided strands relating to the cooperative efforts of rehabilitation and education. Joint meetings of all the organizations in deafness would appear to provide an opportunity to explore and work upon the common areas of interest and con-

cern. Regional, statewide, and local conferences should be encouraged to follow this format, much as the Mississippi Council of Organizations Serving Deaf Mississippians has done since 1978.

There may be yet other devices for triggering greater interaction between rehabilitation and education programs serving deaf people. Nonetheless, it seems that much can be resolved now by clearing away the ignorance, misunderstandings, and occasional negative feelings that professionals in one field have for the other field. If this can be combined with frequent opportunities to interact on an informal (*i.e.*, inservice, professional meetings) basis, then a network of cooperative ties may successfully counterbalance the division caused by or-

ganizational separation. In all of this, the most important factor is a professional expert in his/her field, with a knowledge of the working procedures and problems of the other field, and possessing a personal/working relationship with professional colleagues from the other field.

Dr. Sanders is Administrator, National Leadership Training Program, California State University, Northridge.

The author wishes to express his deep gratitude and that of over 300 graduates of the National Leadership Training Program to Dr. Wayne F. McIntire, who developed the program and has served as its inspiration and mentor since the beginning.

Notes and References

1) The 1983 Joint North American Conventions on Education of the Hearing Impaired, June 27-30, 1983, Winnipeg, Manitoba, Canada. The main organizations involved were the Convention of American Instructors of the Deaf (CAID), Conference of Educational Administrators Serving the Deaf (CEASD), and the Association of Canadian Educators of the Hearing Impaired (ACEHI). The International Association of Parents of the Deaf (IAPD) also participated.

2) *Education of the Deaf: A Report to the Secretary of Health, Education, and Welfare by his Advisory Committee on the Education of the Deaf*. Washington: HEW n.d., p87.

3) *Proceedings of the National Conference for Coordinating Rehabilitation and Education Services for the Deaf*. Las Cruces, New Mexico, November 6-9, 1967.

4) *Ibid.*, pp. 11-12.

5) *Proceedings of the National Training Session on the Rehabilitation of the Deaf*. Las Cruces, New Mexico, April 20-22, 1967.

6) 45 CFR Part 1361.20 (b); regulations implementing the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978.

7) *Annual Report of the National Council on the Handicapped*. March 1983, pp. 40-43.

8) *Models of Exemplary Practices in Coordinating Special Education and Vocational Rehabilitation Services*. A Report Prepared for the National Institute of Handicapped Research, by Harold Russell Associates, Inc., Waltham, Massachusetts.

9) *American Annals of the Deaf*, Volume 107 (April 1962) and Volume 129 (April 1984).

Employing The Disabled

Graham G. Goddard

Microcomputers can provide access to many jobs and professions that would otherwise be difficult or impossible for disabled people. Accounting is one example.

Most people would consider accounting as a physically undemanding profession. Compared with many, it is, of course. But for some people, even a task such as pulling a file folder from a cabinet is more than they can manage unaided.

Diagnosed at age seven as having muscular dystrophy, Scott Lubert became wheelchair-bound at age 13 and is unable to perform many basic tasks. Mr. Lubert, however, is a CPA (he passed the examination at his first attempt) with Nankin, Schnoll & Company, a local firm in Milwaukee, Wisconsin.

Instead of a rectangular desk, Mr. Lubert's office features a circular one. A mechanized Lazy Susan really, the desk rotates at the push of a button to place various pieces of computer equipment in front of Mr. Lubert so that he can accomplish his tasks.

The office is different in other ways. The phone receiver is always "off the hook," suspended at earlevel by a flexible stand. The base of the phone is unusual too. Projecting from it is an ingenious levered bar that, with a simple flip, opens and closes the line.

Although we are living in an age when there are more disabled people in the professions, Mr. Lubert says that there are still not enough role models for young, disabled people trying to decide what to do with their lives. When he was in high school, Mr. Lu-

bert would have liked to have become an architect. That seemed impossible then, however, because of the physical requirements of drafting. With modern computer-assisted design techniques available, architecture isn't such an impossible goal today.

A few years ago, even accountancy seemed unlikely. At interviews, after graduation from the University of Wisconsin-Madison in 1982, firms told Mr. Lubert that he just wouldn't be able to do the job. Howard M. Schnoll, the managing partner of Nankin, Schnoll & Company, thought differently. He told Mr. Lubert that if a way could be found to help him do the work, he had a job with the firm.

The firm contacted Gregory Vanderheiden, director of University of Wisconsin Hospital's Trace Center, and a noted rehabilitation engineer. It was Mr. Vanderheiden who rethought the typical office concepts and designed one for an account with Mr. Lubert's specific disabilities.

The computer, for example, is an IBM, but because Mr. Lubert is unable to operate a standard keyboard, Mr. Vanderheiden routed the keyboard commands through a device called an emulator to a much smaller keyboard—one only seven inches wide. Using the head of a pencil, Mr. Lubert has no trouble issuing commands on this keyboard.

Mr. Vanderheiden programmed the small keyboard so that the keys have three levels of meaning. This enables Mr. Lubert to be computer-fluent while using commands that are physically the least taxing for him.

At level II, for example, the exclamation point is just that—an exclamation point. At level I, however, the exclamation point key becomes the ESCape key. This eliminates the need for dexterity which is typically required for many control functions.

The Lazy Susan desk was designed by another rehabilitation engineer, Donald Warren of Clinical Convenience Products, Inc., Madison, Wisconsin. By hitting a button with a stick held between his teeth (a mouth stick), Mr. Lubert can rotate the desk so that he is facing the computer disk drives, the screen, the small keyboard or some uncluttered work space for miscellaneous tasks. And in simpler fashion, the floppy disks merely have a loop of masking tape attached to make their insertion and removal from the disk drives a little easier.

Personal computers can bring benefits to a wide range of disabled people. A recently released book, *Personal Computers and the Disabled*, by Peter A. McWilliams, addresses some of these benefits and provides a look at the special features available to modify computers for use by the disabled. A point that Mr. McWilliams makes is that a computer costs the same, no matter who uses it, and the special input and output devices don't add much to the price.

Modified personal computers enable deaf people to call and communicate with anyone who has a computer, and blind people, through synthesized voice output, to have access to all

(continued on page 23.)

Obfuscation is a term that defines the art of utilization of many big words on the pretext that these words are

Language Used or Used Language?

Ron Bourgea

The Malaphor. In *Strictly Speaking*, Edwin Newman writes: "Joe Jacobs, manager of the German heavyweight, Max Schmeling, in the 1930s, described his dreamlike condition when a decision unexpectedly went against his man: 'I was in a transom' . . . Before their first fight, Joe Frazier said Muhammad Ali 'He don't phrase me,' and was right on both accounts, and Ali spoke of not being 'flustrated,' which he rarely was. In one of the disputes over rules at the 1972 Olympics, a U.S. swimming coach spoke of signing 'alphadavits.'"

Huey Long was quoted in the now defunct *Literary Digest*: "The Republicans are snakes in the grass who are slowing eating away at the foundations of our Ship of State," to which the Digest commented: "Nice work, Huey: you smelled a rat and nipped it in the bud."

Barbara Plamer, in the now departed *Washington Star* led off her article on "mangled speech" in these words:

"When a state official suggested to a legislative committee that the Maryland General Assembly pass a law requiring that certain tax forms be notarized, one Anne Arundel County senator argued it would be wrong to require 'notoriety.'

"When another committee took up a generic drug bill, a delegate, also

from Anne Arundel, delivered a brief speech in favor of 'genetic' drugs.

"And, when a Baltimore City delegate explained to a reporter his stand on a public utilities bill, he somewhat immodestly described himself as 'just like Sampson fighting Goliath.'"

Here are a few more, from other sources: "That guy's out to butter his own nest." "We are diabolically opposed." "I'm not going to put my neck out on a limb." And, "It may be so, but my guttural reaction is that it won't work."

But malaphors can be used creatively for humor if one wishes, but also for serious purposes: Note Judith Martin's arresting headline in *The Washington Post*: "Skating On Thin Ground" which had to do with the misuse of English. It got your attention.

METHODOLOGY

Superabundance. Sue these words for nonsupport.

• *Appropriate* supervisor, as in, "He will notify his appropriate supervisor of his plans." Appropriately, he would not notify his inappropriate supervisor. Here's the first rule that we have ever printed in this column: *Positive nouns rarely need positive adjectives.*

An appropriate supervisor is much like a *trained* professional, searching the *relevant* literature, walking on a *walking* sidewalk, living in a *living* house (except when the house, of course, is made of living tissue). We are in the mood for rules: Have mercy on your appropriate reader. Please?

• "He is required to take a volunteer or work experience position." To volunteer or to work is an "experience," and they are both "positions." Those kinds of phrases make about as much sense as saying, "He went to work at working his work."

• . . . *Continuing* program. In most cases, the writer is speaking of a program that is in operation and the adjective is superfluous.

• . . . *trained* information specialist. This is much the same case as a *trained* professional, where both "professional" and "specialist" embody the idea of "training." In becoming a specialist in avoiding these constructions, you will become a professional in managing your written endeavors. But you must train yourself in this art.

• ". . . for your own growth and *development*." "Own" is contained in "your" and is extra baggage, and "growth" means "gradual development toward maturity." So, in actuality, the author here has said, ". . . for your your growth and growth."

• "forecasts of *future* employment opportunities." Since a forecast is a prediction, it can only be of a future nature, and doubly so here since "opportunity" has a future sense as "a good chance for advancement." And its definition, "chance," portends coming events as well, so that I would say this expression has a "lot of future;" however, not much thought.

• "He has *actively* worked. . . ." Working embodies activity, if not physical, then mental. Or both.

Careful writing. Simple writing does not necessarily mean clear writing.

•“to provide *factual* data on the costs. . .” Data that are “provided” are a fact. In fact, we wonder if this author was not thinking of such descriptives as “relevant” or “(f)actual,” or “accurate”? But if they were nonfactual, then, of course, state the fact factually with the data identified as nonfactual. . . . And that’s a fact!

•Punch up your punctuation: Punctuation is a pause which few of us give enough pause to. Consider, first, the mish-mash that the first quote would provide without proper punctuation. Then read the comments of other people about its importance.

—John, where Joe had had “had,” had had “Had had;” “had had” had had the professor’s approval.

—I spent all morning putting in a comma and all afternoon taking it out. —**Oscar Wilde**

—Try to remember that the most dramatic, eloquent, and electrifying thing in the English language is the period. —**Debs Myers**.

—The form is the end of the becoming process. —**Aristotle**.



Pastiche.

•In a previous column, I mentioned a statement by Dr. Edwin E. Johnstone that said that “because of a dumb label, a brilliant idea could be overlooked.” While Dr. Johnstone was commenting on an article that he

considered “brilliant,” I’m not sure what Dr. Alexander Kohn thought of the articles which he said had “unfortunate choice of wording for the title.” Here are some of his examples: “An Instant of Pitfalls Prevalent In Graveyard Research” (*Biometrics*, Vol. 19); “Heat and Moss Transfer In a Turbulent Bed Contactor” (*Chem. Eng. Progr.*, Vol 60); and “Freezing and Storage of Human Semen In 50 Healthy Medical Students” (*Fertility and Sterility*, Vol. 15).

• The source of these two items was the *VOA Guide for Writers and Editors*, “On Precise Writing,” page 18:

“ . . . phrases that once were fresh become cliches through overuse. To wit: ‘naked aggression, easy prey, mute evidence, crystal clear, mounting tension, the Middle East powder keg,’ and so on *ad infinitum*. Fortunately, such bromides rarely appear in our copy, and, if they do, they incur the displeasure of copy editors.” Yes, and when they do, they also anger copy editors!

“The language desks have much knowledge and expertise about their countries, and should be consulted on sticky problems therein. Also, confer with the specialists in the newsroom on handling of stories they have spent years with.” If desks could speak, I am sure that they would have many things to say, especially language desks. And I suspect that their “sticky problems” are tucked away in their cliché corner, along with coffee and other food stains. I also wonder what their comment on “knowledge and expertise” would be? Well, so much for speaking with desks, but when it comes to conferring with specialists “on handling of stories they have spent years with,” I don’t have the commitment, the time, or the interest. Sounds like old news to me!

The Promised Land. The difference between the right word and the almost

right word is the difference between lightning and the lightning bug. **Mark Twain**.

As we look and hear and taste and feel, we are searching for what Somerset Maugham sought all his life — “not the right word, but the *inevitable* word.” Edwin Arlington Robinson went through the same experience. Late in life, in a letter to a friend, he wrote of his boyhood struggles to capture a line of poetry. In those days, he said. . .

“time had no special significance for a certain juvenile and incorrigible fisher of words who thought nothing of fishing for two weeks to catch a stanza, or even a line, that he would not throw back into a squirming sea of language where there was every word but the one he wanted. There were strange and iridescent and impossible words that would seize the bait and swallow the hook and all but drag the excited angler in after them, but like that famous catch of Hiawatha’s, they were generally not the fish he wanted. He wanted fish that were smooth and shining and subtle, and very much alive, and not too strange, and presently, after long patience and many rejections, they began to bite.”

Robinson’s experience is common to every one of us who revels in the jewelry of our language. We see words that blow like leaves in the winds of autumn—golden words, bronze words, words that catch the light like opals. We learn that words have an independent life of their own, grown out of echoes and connotations and associations. We see that words are tactile; we find rough words, smooth words, words with splintered edges; words to shout or to whisper with; words that caress; words that strike. After a long while, as Robinson said, we begin at last to catch the words we want. **John J. Kilpatrick**, in his book, *The Writer’s Art*.

Notes on the margin...

FREE NEWSLETTER

"The Open Door" is a breezy, informative newsletter published bimonthly by Asnuntuck Community College. Some of its items are of local interest only, but much of its content has a wide appeal. It is free and can be ordered from the college at P. O. Box 68, Enfield, CT 06082-0068.

SELF EMPLOYMENT MANUAL AVAILABLE

An extensive network of organizations is in place nationwide to assist handicapped veterans and other handicapped people to find employment. Too often in these efforts, self employment is overlooked or given scant consideration.

The volume, "Businesses That Can Be Owned And Operated By Handicapped Veterans" is designed to emphasize self employment possibilities both for the disabled and for those who try to assist them. The book is a "how to" guide. It catalogs 163 handicapped-owned businesses and 86 studies of people in established businesses.

The 258-page manual-compendium has been submitted to the Small Business Administration. Information on availability may be obtained from Leon Bechet, The Office of Veterans Affairs, Small Business Administration, 1441 L Street, N.W., Washington, DC.

RURAL REHAB DATABASE

Information concerning innovations, inventions, or ideas which benefit disabled people who live in rural areas is being requested by the University of North Dakota. It will be compiled into a Rural Rehabilitation Technologies Database (RRTD) for use by professionals and the general public. A catalog will be published in early 1986 containing the entries submitted.

For further information contact Rural Rehabilitation Technologies Database, Medical Center Rehabilitation Hospital, Box 8202, University Station, Grand Forks, ND 58202, or call (701) 780-2489.

PLACEMENT PUB

"Putting Disabled People In Your Place: Focus On Paraplegia and Quadriplegia" is the first in a series of 12-page publications to be issued in 1985 by Mainstream, Inc. on hiring and placing people with specific disabilities.

It offers practical advice on interviewing, accommodating, and supervising persons who have spinal cord impairments. Much of the information also applies to other wheelchair-using people. Specific subjects include making the interviewing process accessible, what to ask and not to ask of a paralyzed job seeker, conducting a job analysis, and what supervisors and coworkers need to know about the new employee and his disability.

Order from Mainstream, Inc., 1200 15th Street, N.W., Washington, DC 20005. Cost is \$7.

UPCOMING MEETINGS

. A second International Conference on Rural Rehabilitation Technologies is being planned for Oct. 22-24 at the University of North Dakota in Grand Forks. Its purpose is to increase awareness of the challenges confronting rural disabled people and to find answers to these challenges. The conference will focus on technology that can assist the rural disabled in farming, independent living, recreation, and other aspects of life. For further information: ICRRT Headquarters, Box 8103 University Station, Grand Forks, ND 58202 or call (701) 777-3120.

. Congress of Rehabilitation's 2nd congress will convene in Vancouver in June 1985. The theme is "sharing expectations in rehabilitation." Contact Canadian Congress of Rehabilitation, c/o Canadian Rehabilitation Council for the Disabled, Suite 2110, One Yonge Street, Toronto, Ontario, Canada M5E 1E5.

. The 1985 National Conference on Independent Living will convene June 19-21 at the Doubletree Hotel in Kansas City. It is cosponsored by the Research and Training Center on Independent Living and the National Council of Independent Living Programs. For a program description, write: R&T Center on Independent Living, AA-313 Bristol Terrace, Lawrence, KS 66044. Telephone: (913) 842-7694.

Enhancing the Attendant Management Skills of Persons With Disabilities

Gary Ulicny and Michael L. Jones, Ph.D.

Attendant care may be one of the most important independent living services for people with severe disabilities. It allows them to receive assistance with personal hygiene, bathing, dressing, and housekeeping in their own homes. Without this help, many people with disabilities would be required to live in nursing homes or be dependent upon family members for their personal care.

Unlike visiting nurses, personal care attendants are typically hired and trained by the disabled person. Initially, the idea that persons with disabilities could train nonmedical attendants was controversial. Now, however, the advocacy efforts of many people have allowed attendant care to evolve into a realistic and legitimate independent living (IL) service.

One of the major barriers to increased use of attendant care is lack of funding. Recently, federal legislation has been introduced (Senate Bill 2053) to shift Medicaid funds from institutional to community programs. This legislation would increase available funding for attendant care services and, thus, markedly increase the number of people who could use the service. Many of these people have spent much of their lives in dependent environments. They may soon find themselves facing the unaccustomed role of employer. Although numerous man-

uals have been written to assist disabled people with attendant care, few procedures have focused on improving management skills.

The need for effective management skills is not limited to people making the transition from dependent to independent living. A literature review suggests the most common problem in attendant care is employers' lack of management skills.^{1,2} Frequently cited deficits include lack of specific job descriptions and the employer's inability to provide effective, objective feedback on attendant performance.^{3,4} Consequently, there is a need for procedures that enable people with disabilities to train and manage their attendants more effectively.

For the past year, the Research and Training Center on Independent Living (RTC/IL) has been developing procedures that address this problem. Similar procedures have been used successfully to train and supervise caregivers in other settings, such as day care centers and nursing homes. Taken together, the techniques form a model of attendant care management.

This model attempts to overcome management deficits by using performance checklists to outline specific job descriptions.^{5,6} Each checklist details the steps in a given work routine (health care, housekeeping, environmental maintenance, etc.). Checklists

can also include information on how often routines are to be performed, materials needed, and set-up procedures. Checklists not only provide instructions to the caregiver, but also help the employer monitor, evaluate, and provide feedback to the caregiver on his or her performance. Once training is completed, checklists can be used for continued supervision. By using the checklists to periodically re-evaluate and provide feedback to the attendant, consistent performance can be maintained.

The model was designed to ensure consumer choice and control. While we have provided general suggestions and assistance, each person is responsible for developing personalized checklists. They determine what, how, and how much attendant care will be provided.

The first step is for the disabled person to determine what areas of personal care he or she needs help with. General categories, like bathing or housekeeping, are selected from a prepared list. From these general categories, the person can choose areas in which they need attendant care.

Developing personalized checklists involves listing exactly what duties the attendant is expected to perform. This can be done from memory, by having someone record each duty while the routine is being performed, or tape re-

cording verbal descriptions of each routine. The important thing is that the checklists contain each duty the attendant will be required to perform.

To assist with formatting the personalized checklists, we provide generic checklists and examples of actual personalized checklists developed by consumers. We accent the fact that these are only to be used as a reference guide, since their checklists should reflect their own requirements. Table 1 reproduces a generic checklist developed for bathing assistance. Additional generic checklists have been developed for bowel and bladder care, meal preparation, housekeeping, shopping, range of motion, transfers, and wheelchair maintenance.

Using Checklists to Train Attendants

The first step in training a new attendant is to make sure he or she understands each checklist item. One way to do this is to have a former attendant model the behavior, while the new attendant follows along on the checklist. When not possible, the employer can simply explain each item to the new attendant. Once the attendant is familiar with the routine, he or she is ready to begin on-the-job training.

One of the checklist purposes is to give the attendant a visual picture of what needs to be done, when it needs to be done, and in what order. During training, the employer can enlarge and post the checklists where the attendant can read them while performing the routine. This is especially useful for tasks like house cleaning where the employer cannot always watch and give instructions. While the checklists outline *what* needs to be done, the employer is still responsible for providing detailed instructions during training to ensure that the attendant knows *how* he or she wants the task performed.

Immediately after the routine is finished, employer and attendant review each item. The employer scores each item as "correct" or "needs improvement." If the item is scored as correct, the employer gives the attendant positive feedback. He or she describes exactly why the task was performed correctly. For example, "You really did a great job of combing my hair. You put the part right where I like it." If the item needs improvement, the employer explains why it was done incorrectly and gives specific instructions on how to correct the problem. Using the same example, "We need to work on combing my hair. I prefer my part a little more to the left." Feedback ses-

sions ensure that the attendant receives positive feedback for correct performance and specific instructions to correct areas that need improvement.

Using Checklists to Supervise Attendants

Probably the most important part of management is the quantity and quality of feedback an employer gives to employees. In most employment situations, employer feedback is given only when the employee has done something wrong. In contrast, *ongoing* performance feedback, both positive and corrective, is a major feature of our model. Monitoring perform-

Table 1
Generic Checklist for Bathing

- A. Preparation**
 - 1. Get clothes ready.
 - 2. Prepare bath water.
 - 3. Check bathroom temperature.
 - 4. Make sure needed materials are available.
 - 5. Ensure privacy.
- B. Routine**
 - 1. Assist in clothing removal.
 - 2. Move from bed to bath.
 - 3. Wash and rinse body.
 - 4. Assist with hair care.
 - 5. Move from bath to dressing area.
 - 6. Dry body thoroughly.
 - 7. Conduct health check(e.g., check for pressure sores).
 - 8. Apply lotion or powder.
 - 9. Apply deodorant, makeup, and/or shave.
 - 10. Assist in dressing.
 - 11. Assist with bladder and bowel care.
 - 12. Move to wheelchair.
 - 13. Assist with dental care.
 - 14. Move to breakfast area.
- C. Clean up**
 - 1. Put away all materials.
 - 2. Clean bathroom.
 - 3. Clean and disinfect bladder and bowel care materials.

ance regularly ensures that the majority of feedback is positive and enables small problems to be corrected before they become big problems. Once the employer is satisfied with the attendant's performance, feedback sessions are faded from daily to monthly. For ongoing supervision, feedback sessions are conducted in the same way as during training.

Using Checklists to Hire Attendants

The checklists can also serve a variety of administrative functions. When interviewing a prospective attendant, applicants can review the checklists so they know exactly what will be expected of them. Upon hiring, checklists can serve as a job responsibility contract. This contract can be referred to throughout the employment period. The contract protects both employer and attendant by providing a permanent record of job responsibilities. Finally, checklists serve as a record of attendant performance. This can be useful to the employer should he or she be asked to provide a reference or be forced to fire an attendant.

We are currently conducting a series of pilot studies to test our procedures. A 28-year-old male with a C5 spinal cord injury was our first participant. Prior to implementing the model, his attendant made errors consistently. After incorporating the checklists and receiving training in management skills, his attendant made significantly fewer errors.

One interesting factor was that before the model was implemented, both unimportant errors and critical errors occurred. However, once the model was implemented, errors were confined almost exclusively to tasks without harmful consequences.

We plan to continue tests and revisions. We have also identified various additional study areas which include

developing procedures for implementing the model in service agencies, developing videotapes and computer-assisted instructional materials, examining the employer/employee relationship as it relates to attendant care, and identifying new labor markets where disabled people can locate attendants. For example, people who are mentally retarded are often unemployed and may be an excellent source of personal care attendants.

Conclusion

The IL movement has described the relationship between people with disabilities and attendants as an employer/employee relationship. In the business world, employers can use research to make decisions about employee management. The purpose of our project is to provide disabled people with that same advantage.

In addition to increasing management skills, a systematic attendant care model may have other benefits. The present federal administration has adopted a stance of fiscal conservatism, especially in the area of human services. Future funding will almost certainly depend on a program's ability to demonstrate cost effectiveness and accountability. If we are to maintain consumer control of attendant care, we must be able to respond to these fiscal and evaluative stances.

The traditional rehabilitation approach to attendant care has been to train attendants. In the course of a disabled person's lifetime, he or she might employ 50 attendants (a conservative estimate). Sense dictates that it would be much cheaper to train one person systematically in his or her specific routine than to train 50 attendants in generic procedures.

Another threat to consumer control is certification. Many medical professionals continue to be skeptical about nonmedical personnel who provide as-

sistance to people with severe disabilities. They insist that attendants need to be certified in basic procedures. If access to funding should require certification, our position is to certify attendant care users rather than attendants. In fact, several states currently require people with disabilities to demonstrate competency in training attendants to receive Medicaid funds.⁷ Our model provides consumers with a method of demonstrating that competency.

Mr. Ulicny is a research assistant with the Research and Training Center on Independent Living at the University of Kansas. Dr. Jones is its Training Director.

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Speech Products Are Impacting The Rehabilitation Field

John M. Williams

Technology is moving too quickly for most people to grasp the full impact of it upon their lives. A revolutionary technology that is gaining impact and momentum in the lives of disabled people is speech technology. It is also gaining momentum and having a lasting impact in the rehabilitation field.

"There is no doubt that talking computers, terminals, and peripherals associated with them represent an extremely important technological advance in the rehabilitation field. The first time I heard synthetic speech from a terminal, I saw multiple benefits for the disabled user, including blind, speech-impaired, and visually-impaired people. I could see where this technology would be extremely valuable to our clients working in computer-related areas," says Billy Montgomery, Maryland Rehabilitation Center, Baltimore.

He is supported by many people in the rehabilitation profession from Maine to California. Some of his supporters include Paul Rourke, Director, Maine State Bureau of Rehabilitation; James Vagnoni, Director of the Physically Handicapped Training Center, University of Pennsylvania; Ralph Bishop, area supervisor of Vocational Rehabilitation for 20 Alabama counties; Nancy Koppel, instructional supervisor, Division of Rehabilitation Services, Omaha, Nebraska; and Jim Cunningham, Central Ohio Rehabilitation Program, Columbus.

Users of speech products, who were introduced to them during training programs at rehabilitation centers or under rehabilitation supervision, praise them also. One such person is Mark Rew.

Rew is a computer programmer in the software engineering division of the National Weather Service, Silver Spring, Maryland. Early in 1984, he spent 9 weeks of training as a programmer at the Washington Suburban Sanitation Commission, Washington, D.C.

"I used a Total Talk, a talking terminal that is manufactured and distributed by Maryland Computer Services, Inc. Another blind person and I received on-the-job practical experience. Whether we were in class, writing COBOL (Common Business Oriented Language) programs, or learning data base management, we were as efficient as sighted people. The talking terminals eliminated our disability and provided us with the incentive that told us we can compete and be trained with sighted people," said Rew.

While he was being trained, Rew, who enjoys a challenge, worked on several statistical programs that converted data into a form that could be used for data management.

"Even though I could not see, I knew where I was all the time because of the talking terminal. I was able to review the material a word, line, sentence, or page at a time. I would not have been able to complete the course, neither would the other blind person,

without the talking terminal," he stresses.

"We are living in a computer age that is providing numerous educational and employment opportunities for disabled people. Speech products are essential to the millions of blind, visually-impaired, speech impaired, and other disabled people in the country," said Deane Blazie, leading computer scientist and president of Maryland Computer Services, Inc. "Rehabilitation is a natural field for talking computers, terminals, and the peripherals accompanying them."

According to Rourke, from the Maine Bureau of Rehabilitation's Division of Eye Care, he has been using talking products for nearly 3 years. His agency has purchased five talking computers for people who have gotten jobs with private insurance companies and mail order catalog services.

Under the Bureau's policy, the talking products belong to the users while they are in training or are using them in their employment. If a user completes a training program or does not use it at work, the computer or terminal is returned to the state.

"Our clients and their employees have been very impressed with our talking computers and terminals. One computer that particularly impressed them is an Information Thru Speech talking computer.

"Its versatility is remarkable. The speech is easy to understand. It has an unlimited speech vocabulary, a rate of speech ranging from 45 to over 700

words per minute; it can produce materials in Braille and perform many other tasks that are necessary for today's job market," said Rourke.

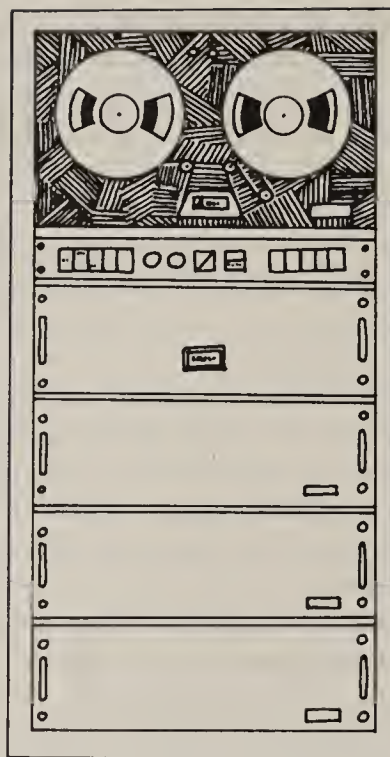
Cunningham, Bishop, Montgomery, and other rehabilitation counselors also have been using speech products for years. They use them in their training programs. Most of them see speech products as a benefit to disabled people whose disability is other than blindness, visual-impairment, and speech impairment.

"It is very true that talking computers and terminals and other speech products assist blind, speech-impaired and the visually-impaired people. These products can be the eyes and voices for people with the disabilities I have just mentioned.

"However, we in the rehabilitation profession must understand that speech products, (I mean primarily a talking computer such as an Information Thru Speech, Apple's Echo II, VOTRAX Personal Speech System, Intex Talker and others) can help the quadriplegic, autistic adults and children, paraplegic, and the learning disabled child and even adults," said Bishop.

"I have retinitus pigmentosa and a very noticeable lisp. I was trained as a computer programmer with a talking computer. I spent a year in a rehabilitation program learning programming and learning how to enunciate my words better so I could get a job. My blindness and lisp worked against me when I went for a job interview. I have been employed now for nearly 2 years. I would not be if it had not been for my talking computer. I practice my pronunciation nearly an hour a day with it," says Mike, a Chicago based programmer.

Mike's best friend is a quadriplegic. They spend many hours together working on programs and setting up a business plan for a consulting business



they plan to open next year. Mike says, "Darren uses a talking computer. It is a blessing to him. He uses it to write with. It is his proofreader, speller, editor, and grammarian all wrapped into one.

"While Darren is slow. He uses it very effectively. When I get a memo, an action plan, or any other written material from him, it is letter perfect. There isn't a misspelling, a typographical error, or incorrect punctuation on the page. He could not work this efficiently without his talking computer," said Mike.

A former Viet Nam Veteran, Darren was trained in Santa Monica under a project called Systems Development Corporation, a state-supported program.

While there, he became familiar with a talking terminal. He saw an opportunity for himself to use this unique technology to his benefit.

"I became friends with some blind students at the corporation. They taught me to use the computer. They provided leadership examples. When I saw what they could do, I decided to

master the computer," said Darren.

The blind students Darren knew were part of a rehabilitation program.

Moving eastward to Ohio, Cunningham is proud of the personal and professional accomplishments he has seen disabled people, particularly blind and visually-impaired people, achieve because of these products.

He has seen self esteem grow because they are doing work that was once thought impossible for them. He has seen them develop computer programs, write reports, deliver speeches, and become business and community leaders.

"We cannot minimize the value of speech technology among our clients, and those disabled people who are not our clients. Currently, blind and visually-impaired people are the biggest beneficiaries of speech output. Our task is to provide them and other disabled people with the technology and the training to improve their quality of life personally and financially. There is a great deal that has to be done. It is a never ending challenge, but one I enjoy, as do so many other rehabilitation counselors.

"Thanks to computer technology, (and right now to speech technology), the world is changing for disabled people. It is an exciting time for use in the rehabilitation profession to be providing leadership for disabled people," Cunningham said.

Even though speech technology is relatively new in the rehabilitation field, in the last 5 years, there have been hundreds of success stories due to it. The future holds tens of thousands more to come. The future holds a challenge for rehabilitation agencies and businesses to work more closely together to help disabled people become independent. Rehabilitation professionals are working to achieve this goal, and they are making a difference for the better.

Tim Cranmer, former director of Technical Services for the Blind, Frankfort, Kentucky and a leading pioneer to assist blind people, says, "Rehabilitation counselors and businesses such as Maryland Computer Services, Inc., IBM, and Telesensory Systems, and some others are making progress in working together to ensure that disabled people benefit from today's technology. This is true leadership."

Speech output technology for a variety of handicapping conditions looks like the breakthrough that has been awaited. In a literary way, it reminds one of the person of Sisyphus in Greek Mythology who was condemned to perpetually push a stone up a mountain only to see it roll back to where he started. Speech output technology breaks through the myth that relegated the handicapped person to continually start from the bottom. For

many, technology can end to the continuous climb that the past required from them.

Mr. Williams is President, Technical Communications, Sterling, Virginia. He has published computer-related articles, as they relate to handicapped people, in several journals.

More Notes from a Different Drummer, A Guide to Juvenile Fiction Portraying the Disabled. Barbara H. Baskin and Karen H. Harris, authors. R.R. Bowker Company, 205 East Forty-second Street, New York, New York 10017. Hard cover 495 pages, \$27.50.

This book describes and evaluates 450 works of fiction with a readership level from infancy to adolescence. Each book is listed by author, title, and publisher, giving reading level and a description of the disabilities portrayed. In addition, an extensive analysis of the possible use of each of the 450 titles and a critical evaluation are provided.

Its companion volume, *Notes From a Different Drummer*, was named an ALA Reference Book of the Year in 1977, and covered works written between 1940 and 1975. This current title complements the first edition with 450 new titles written since 1976. Included are picture books, junior novels, fiction of all kinds, foreign titles distributed in the U.S., and out-of-print books most commonly found in children's collections. Not considered were publishers' formula romances, folklore, and novels that expound a particular religious belief. However, books that feature religious characters and settings that are part of the overall story are included.

EMPLOYMENT

(continued from page 13.)

the information—news, research, data banks, etc.—available to personal computers. Voice synthesizers give voice to the voiceless, and computers allow people with muscular, motor, and movement disabilities to work and communicate far more effectively than ever before. Disabled people who have control of only an eyebrow, eyelid, finger or toe can communicate unaided with unlimited vocabularies.

The book contains an extensive guide to computer equipment, software, and services designed especially for disabled people, and a listing of the resources—associations, agencies, programs, and information—available nationwide.

Other Resources

One resource center set up specially to help firms determine what physical and other accommodations are necessary to help disabled employees do their work is the Job Accommodation Network, based at West Virginia University in Morgantown.

The network was established by the President's Committee for the Employment of the Handicapped and is financed jointly by the National Institute of Handicapped Research and the Rehabilitation Services Administration. Its computer data base contains

almost 4,000 ideas for accommodating disabled employees; and its consultants try to minimize stereotyping by basing suggestions on a person's functional limitations rather than on the specific disability.

Mr. Vanderheiden is pleased about what is being done to help disabled people lead productive lives but thinks it is important to remember what yet needs to be done. He says there are too many types of disabilities for them to be approached on a case-by-case basis and dreams of a system that could take notes, answer the phone, run any piece of standard software, and adapt to the varied needs of disabled people.

Mr. Vanderheiden's skill as a rehabilitation engineer has certainly enabled Mr. Luber to be productive. He performs some tax work but, in close alliance with Bruce Champion, the partner in charge of the firm's management advisory services department (microcomputer services), is mainly involved in preparing computer models to solve problems encountered by clients. Mr. Luber also ably performs another function—namely that of role model to other young, disabled people trying to decide what to do with their lives.

Mr. Goddard is Editor, *The Practicing CPA* and this article is reprinted from its January 1985 edition. Copyright © American Institute of Certified Public Accountants, Inc.

REPORT RESOURCES

NARIC'S REHABILITATION RESEARCH REVIEW SERIES.

The National Rehabilitation Information Center (NARIC), which operates under contract to the National Institute of Handicapped Research, U.S. Department of Education, has developed a number of publications in the **Rehabilitation Research Review** series. They are a cooperative effort of NARIC and the National Council on Rehabilitation Education. Each review contains a state-of-the-art analysis of the literature on a specific topic, an annotated reference list, and recommendations for future research.

Those interested in purchasing reviews may send order to: Data Institute, The Catholic University of America, 4407 Eighth Street, N.E., Washington, DC 20017, (202) 635-5826. The charge of \$9 for each review includes postage and handling, and is good through October 31, 1985. People interested in authoring Reviews or in suggesting topics for future Reviews may contact Ms. Freddi Karp at the above address and phone.

Here are some of the titles available:

Private Sector: Role of Rehabilitation Professionals. George N. Wright, Ph.D., University of Wisconsin-Madison. This review describes the roles of rehabilitation counselors in proprietary rehabilitation as distinct from functions of professionals in nonprofit rehabilitation. Wright details specific goals and strategies employed in private sector rehabilitation, including insights and guidelines gleaned from personal experience, as well as from the literature.

Incentives and Disincentives in the Vocational Rehabilitation Process. Written by Kurt L. Johnson when he was a doctoral student at the Univer-

sity of Wisconsin—Madison. Johnson discusses findings which relate financial disincentives to characteristics of disabled people (including severity of disability, education, and age) and rehabilitation outcomes. He also covers limitations of available research on the subject.

Rehabilitation Education and Training. Michael E. Scofield, Ph.D., St. Mary's Hospital, Passaic, New Jersey. In his critical examination of the literature, Scofield found that most studies testing the effectiveness of training focused on interpersonal skills of trainees and attitudes and other personality variables. He also details findings of efforts to describe and evaluate training strategies, program models, and curricula.

Benefit Cost Analysis. Monroe Berkowitz, Ph.D., Rutgers University, and Edward Berkowitz, Ph.D., George Washington University. This review contains a comprehensive discussion of cost benefit analysis, its history, an its strengths and weaknesses as a tool for justifying vocational rehabilitation.

Community Integration of Disabled People: Attitudinal and Behavioral Reactions of the Nondisabled. Carol K. Sigelman, Ph.D., Eastern Kentucky University. Sigelman examines areas where attitudes impact on successful social and vocational integrations: attitudes of educators, peers, employers, parents and families; deinstitutionalization and community residential living; and stigmatization and social interaction. She also discusses literature or interventions which alter reactions.

Client Vocational Assessment. Norman A. Berven, Ph.D. University of Wisconsin—Madison. Berven analyzes literature on instrumentation,

assessment programs, the effects of vocational assessment, factors influencing client performance, and clinical decision making. He makes the point that a sounder empirical base is needed for studies in this field.

Process, Issues, and Needs in Private-for-Profit Rehabilitation. Mary Ellen Mitchell, M.Ed., and Jack M. Sink, Ed.D., both of the University of Georgia. The authors address questions, such as: Can the concerns of the business model and the human service model be successfully integrated into the rehabilitation process? Will the efficiency orientation of the business model give rise to further assessment of the public model? Must the humanistic orientation of public rehabilitation practices diminish as a result? In addition, the authors explore some issues still to be resolved by professionals in private sector rehabilitation.

This report was compiled by Inez Fitzgerald, National Institute of Handicapped Research.

ABILITATING THE DISABLED: POLICY ISSUES AND PROGRAM REALITIES—THE VIEW FROM GREECE, Aliki Coudroglou, D.S.W., School of Social Work, Arizona State University, *Fellowship Report #21/World Rehabilitation Fund, Inc.*

The study contributes to our understanding of factors influencing the integration of the disabled in the mainstream of society. Borrowing the International Labor Organization's viewpoint that such integration is best achieved through enabling "a disabled person to secure, retain and advance in suitable employment," (Compte Rendue, 1983, 27A, p. 2) the study focuses on the opportunities allowed the disabled to fulfill that

most important social role: job holder.

This study was undertaken in order to assess Greek social policies regarding disability and the ideological framework within which they operate. The study focuses on whether formulation of policy supported the disabled's integration in society's mainstream. The approach is analytical, for the objective was to assess whether existing social provisions facilitate the disabled's integration into society. Included in this mix is the Greek society's ideological framework within which policies and programs operate.

For copies contact: John King, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

JOB MODIFICATIONS: CASE PRESENTATIONS OF JOB MODIFICATIONS THROUGH ADAPTIVE EQUIPMENT, *Aids and Appliances Review*, Carroll Center for the Blind, Issue No. 12, Spring 1984.

In the area of job placement, the revolution in technology has created new problems for providers of direct services to the blind and visually impaired population. This issue of *Aids and Appliances Review* demonstrates that job modification through adaptive or adapted equipment can be undertaken systematically and effectively even by those who may feel technically inexperienced. The case presentations included in this issue can serve as models to demonstrate both the practical applications of a variety of sensory aids in the workplace as well as the total process of developing a job modification to suit the practical strengths and limitations of a specific person. Each case

presentation demonstrates a course of development unique to the particular job modification.

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PHYSICAL THERAPY AND THE TREATMENT OF ADULT HEMIPLEGIA IN BRAIN DAMAGED INDIVIDUALS, Mary Ann Morrison, M.A., Associate Professor, Program in Physical Therapy, Marquette University, Wisconsin (World Rehabilitation Fund Fellowship #25, January 15-March 24, 1984)

This fellowship report should be of concern to physical therapists and other health care providers who are interested in the rehabilitation of stroke and brain damaged individuals. One of the main goals of the visit was to determine if physiotherapy clinics and rehabilitation centers in Great Britain and Europe are using one particular approach to the treatment of the adult brain damaged patient. The physiotherapists observed basically were schooled in the Bobath Approach but frequently used techniques from the Rood or Brunnstrom Approach.

For copies contact: John King, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

REHABILITATION ENGINEERING CENTER FOR THE EVALUATION AND RESEARCH OF DEVICES FOR THE SEVERELY DISABLED, Summary Final Report, April 1983 (Covers Research performed from December 1981 to December 1982),

Department of Rehabilitation Medicine, Institute of Rehabilitation Medicine, New York University Medical Center.

The REC had two principal core areas: engineering and clinical evaluation of assistive devices for the disabled and research to develop assistive devices for the disabled when suitable devices are not available commercially.

Standardized formats have been developed for specifying the minimum functional performance requirements of electronic assistive devices for the severely disabled and for the test protocols for demonstrating compliance with these specifications. A standard format for recording engineering evaluation and test results has been designed for use in a computerized information and data retrieval systems.

For copies contact: John King, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

WORKING WITH FAMILIES WITH DISABLED MEMBERS: A FAMILY SYSTEM APPROACH. RTC on Independent Living, University of Kansas, 1984.

For social workers, counselors, and psychologists, the growing awareness of the crucial impact of families on their clients has led to the development of family systems theory. Family systems theory is more than a therapeutic technique; it is a philosophy that searches for the causes of behavior, not in the individual alone, but in the interactions among the members of a group.

This training manual outlines a family systems approach to serving disabled persons and their families.

Summer Work Experience Program

Judy Irwin

Michelle Karnow is a 20-year-old student of computer technology at Stanford University who is having no problem making the transition from school to work. Blind since birth, she has never let her disability stand in the way of her capabilities in math and science. When the time came to choose a college, she chose one of the best.

Michelle has gotten some help in taking this step as a participant in a summer work experience program for blind students offered by the Oregon Commission for the Blind. Through this program, she worked as a computer programmer at a local community college and had a chance to develop the discipline and independence so important to pursuing her career.

Michelle is one of many students who have benefited from the agency's Summer Work Experience Program (SWEP) since it was started in 1974. One of the first programs of its kind nationwide, it was designed to give blind students a chance to develop the basic job skills that nondisabled teenagers acquire in a typical summer job—including showing up for work on time, following instructions, and cooperating with fellow workers. Without this kind of experience, blind adults often have difficulty finding and succeeding in employment.

Each summer, about 30 students (age 16-21) come to Portland from throughout Oregon to participate in the program. They are given one week of orientation before beginning their jobs, during which they are given

training in mobility skills and an introduction to the local transit system. The jobs last from 4 to 7 weeks.

Students are encouraged to be independent when possible. They are required to interview for the job before being hired, and, once the job starts, they are responsible for getting to work on time. Students from out of town live in a dormitory where they are expected to cook, clean, and shop for themselves. For many, this is the first time that they have been away from home or on their own.

The jobs are in a variety of fields, depending on interests and abilities. Participants have worked as receptionists, landscapers, daycare workers, computer programmers, and many other jobs.

As a result of this basic work experience, many students are able to go on to find satisfying jobs or enter demanding academic programs. One student, who worked as a file clerk, went on to become assistant manager of a restaurant. Another, who spent three summers working as a presence investigator for a county corrections department, now attends law school. A third student, who worked one summer as a public relations representative, now writes for his local newspaper.

The program has helped students who are not only blind but multiply handicapped. Last summer, five participants were deaf-blind and three used wheelchairs. As with all participants, care is taken to place them in a

job suited to their capabilities. Students with multiple handicaps have worked as kitchen aids, clerical assistants, and assembly workers in the agency's industries program.

One student, who is both blind and diagnosed as having brain damage, surprised his counselor and his employer by tackling tasks that both thought were beyond his ability. He was placed in a restaurant as a dishwasher, but soon he was not only washing dishes but busing tables and chopping vegetables. At the end of the summer, the employer said he would offer the student a job if there were an opening.

To make the program work, it has been necessary for the agency, which works mainly with adults, to adapt its vocational services for young people. This has involved learning how to work with schools, finding new sources of funding, and finding ways to offer quality services for this age group.

Working With Schools

One of the first challenges was to develop a good working relationship with special education teachers throughout the state, since they would be referring students. This required bridging the communications gap that often exists between special education and vocational rehabilitation. To inform teachers about the new program, an agency mobility instructor contacted his public school counterparts through a statewide professional orga-

nization. These teachers then spread the word to their colleagues. In later years, agency staff have made presentations to teachers at public schools.

Another hurdle in working with schools has been that the goals and procedures of the two fields are often different. Whereas education is available to everyone, vocational rehabilitation services are available only to those who are eligible. Occasionally a teacher refers a student who is not capable of working independently. The program is not equipped to deal with students who cannot live independently or function without support staff always available. It can be difficult to explain to the teacher that the student cannot be admitted to the program.

The relationship forged with schools has grown strong enough over the years so that there has been no trouble recruiting students. Each year, teachers refer from 25 to 30 students, which is about the number the program can accommodate. Only 4 students have been turned away in 10 years, all because they didn't possess the minimum ability to function in this unstructured and often unsupervised environment.

Obtaining Funding

A second challenge has been to seek funding. Because SWEP is not a traditional vocational rehabilitation program, a single source of funding has not been available. Instead, funds have been raised piecemeal and from a variety of sources.

Wages are paid not by the employer but first through CETA and, more recently, through JIPA, two federal programs that provide work experience for young adults. Staff time is paid for by the Commission for the Blind from its state general operating budget. Students' living expenses for the first month are also provided by

the agency. Extra funds have been received from the federal Department of Vocational Education and, more recently, by the Oregon School for the Deaf to fund students not supported by CETA and JTPA. Occasionally, an employer pays for the student's employment.

A problem with relying on CETA and JTPA funding is that it is doled out on a local basis for jobs within the student's county of residence. Since SWEP students leave home to work in Portland, they would normally be ineligible for these funds. To work around this, agency staff meets with JTPA officials from each county to persuade them to waive the rules on a case-by-case basis. Sometimes they are successful; other times they are not.

Needless to say, this is a time-consuming and often uncertain method of funding. It would be far simpler to fund the program from one source. The agency is always looking for a permanent source of funding, but, so far, has not found one.

Recruiting Employers

While finding students and funding has been a major undertaking, finding employers has not. Because they are not asked to pay the students' wages, employers have willingly participated in the program. And, although employers are often uncertain about what a blind person can do, in most cases, they are pleasantly surprised. About half continue to participate in the program after their first year. Some have offered the student a permanent job.

Promoting Independence

Perhaps the most challenging part of running the summer program has been learning to work with teenagers. Agency staff believe in providing as little structure as possible, encouraging students to take care of themselves

so they learn to be independent and responsible. But, because this is often the first time they have been on their own, some students abuse their freedom. As do nondisabled teenagers, they sometimes stay up too late, drink too much, run into trouble with the opposite sex, or show up late for work.

The program is structured to give staff a chance to check on students without interfering with their independence. A dormitory advisor lives in the dormitories with students to help organize social activities and to help with problems that arise. Counselors check in with this dorm aide regularly and ask about discipline problems. Counselors also informally check with employers when they pick up the weekly time sheet that is needed for the JTPA payroll.

The most important method of monitoring is a weekly evening discussion session called, "Wednesday Night Live." Students discuss problems they have with employment and share experiences. Since this is the first time most participants have held a job, this comparing of notes can be important to learning. For example, one evening a student asked, "Are all bosses mean?" When some students responded that their bosses were not mean, he understood for the first time that he had a special problem with his boss.

The discussion sessions are also used to teach students job hunting skills, which is a requirement of JTPA. In addition, guest speakers discuss areas of special interest. Speakers have included employed blind people, a spokesperson from Planned Parenthood, and a state employment specialist.

When there is a problem, a counselor steps in if it is affecting the student's work or his relationship with fellow students. Sometimes a student

has trouble performing the job he is hired to do. In these cases, the counselor intervenes with the employer, suggesting new adaptations or modifications in the job description. Generally the employer is receptive.

Discipline problems are harder to handle. In many cases, it is unclear whether the student is having trouble because of his disability or is intentionally breaking the rules. For example, a student who was repeatedly late for work lied by telling his counselor that he was getting lost each morning. The counselor offered to ride with him on the bus one morning to see what the problem was. During the ride, the bus driver unwittingly informed him that

the student usually slept until the end of the line. That was the end of that problem.

In another case, a counselor discovered that a student didn't go to work when it was raining because he worked out of doors and didn't want to get wet. The student did not know that this was an unacceptable reason for missing work. Once the counselor explained this, the student cooperated.

Most discipline problems have been resolved in this way. If they cannot be resolved, the student is expelled from the program. Only three students have been kicked out since the program began 10 years ago. One was fired, one had a drinking problem, and one was

uncooperative with his fellow students.

Such problems, though, have been the exception. The program has consistently turned out successful, career-bound alumni. And although it would be difficult to prove whether or not their success is due to the program or to their own talents, it seems safe to say that the chance to work at a summer job has given them a good head start. Michelle Karnow and her fellow students are glad to have had this chance.

Ms Irwin is Executive Assistant, Oregon Commission for the Blind, Portland, Oregon.

PUBLICATIONS & FILMS

Employers as Partners: A Guide to Negotiating Jobs for People with Disabilities. Charles Galloway. California Institute on Human Services, Sonoma State University, Rohnert Park, CA, 94928. \$6. 42 pages.

This handbook describes the Employer Accounts Strategy, an approach for negotiating career options for people with disabilities that involves a partnership between an employer and a rehabilitation professional. Using methods developed in the fields of marketing and sales, rehabilitation counselors meet the needs of both employers, who want trained and capable employees, and clients with disabilities, who want meaningful jobs in mainstream settings. The strategy emphasizes the establishment of mutually beneficial arrangements in which a rehabilitation agency offers a package of services to an employer in exchange for improved employment opportunities for the agency's clients. This book is useful for both employers and rehabilitation

agencies; it is a bridge between the world of business and the world of rehabilitation.

What Are Friends For? Lorraine G. Hiatt, Robert Brief, Jaime Horwitz, and Cheryl McQueen. American Foundation For The Blind, Inc., 15 West 16th Street, New York, New York 10011. \$24.95 (Package includes Guidebook, the "Big Pad," a flip chart with large captioned illustrations, and a poster.)

Getting together . . . learning from each other . . . sharing information . . . that's what the self-help package for older people, "What Are Friends For?" is all about.

The package is a self-help/peer discussion program which encourages older people who are experiencing impairments in their vision, hearing or memory, to work together to identify their needs; to learn how to modify the physical and social environment to meet those needs; and to compensate for the loss of one sense

through better use of their other senses.

Anyone can take part in these discussion groups . . . people who are already experiencing sensory changes . . . people who have friends or family members who are . . . or people who just want to stay informed. Everyone is an "expert" and can speak from the "voice of experience" to expand the knowledge of the group.

The guidebook contains a chapter on how to guide self-help discussions and specific information on four discussion topics: making your personal environment work for you; making close work and the visual surroundings easier to use; improving communication with others, and remembering things we don't want to forget. Each chapter also includes ideas and materials for followup discussions and activities, as well as a list of additional resources and references.

The big pad is a self-standing flip chart with large captioned illustrations that correspond to the major ideas covered in each discussion.

The poster is designed for distribution in the community.

Computers And The Disabled

A Review Of Three Books

By Dale Brown

Today we know that computers are not terrifying machines, but ordinary tools. They have become helpful to disabled people in their rehabilitation, employment, and in their ability to live independently. They have reduced rehabilitation paperwork and are helping teachers in special and regular classrooms.

As a result, technology has become a major issue in the profession of rehabilitation. Suddenly, every conference seems to sprout the word "technology" or "computer" in its theme. Exhibit halls are filled with whirring computer terminals. We hear computer jargon everywhere.

Obviously, rehabilitation personnel have to sort this information to choose the best and most cost-effective technology for their clients' needs. Three recently published books can help in computer choice and use.

Personal Computers & Special Needs by Frank G. Bowe, Sybex Computer Books, 1984. Frank Bowe Associates, Room 138, 1500 Massachusetts Avenue NW, Washington D.C. 20005. \$11.95.

The author is the former Executive Director of American Coalition of Citizens with Disabilities and is himself a deaf man. He writes with a solid knowledge of the needs of disabled people.

Disabled people, who know little about technology, are his major audience, although parents, advocates, and rehabilitation providers will find the book useful. His engaging style

holds the reader's attention, as he recounts interesting stories of particular disabled people who use computers. For example, he describes Judge Leonard Suchanek, at General Services Administration, who uses a computer that receives and prints braille messages, uses two other computers, and a Kurzweil reading machine. Bowe shows how this technology makes it possible for this blind man, who also has a partial hearing loss, to keep up with an "overwhelming reading load."

The book shows how computers help with employment, independent living, and education. One chapter is devoted to each of four disabilities: blindness, deafness, mobility limitations, and learning limitations. The resource guide at its end is brief; thus providing a small start for the person just beginning to learn about technology.

This book is helpful, particularly to the people who are unaware of computers. However, it has been criticized for being superficial and lacking depth in its presentation. People who already are familiar with technology and disability may not learn anything new.

Microcomputer Resource Book for Special Education by Delores Hagen, Reston Publishing Company, 11480 Sunset Hills Road, Reston, VA 22090. Cost \$15.95.

Delores Hagen, mother of a deaf son, Marc, writes passionately about the potential of computers in educating

disabled children and bringing them into the computer age, where they will have equal access to information. She sometimes talks about her son, but does not let her experiences with him overwhelm the reader.

She is unafraid to criticize the educational establishment for its tendency to ignore the strengths of disabled children and to fit them into the bureaucracy rather than trying to help the student. She also believes it is doing the same with the new technology, i.e., trying to make the computer fit into the curriculum rather than expanding the educational opportunities to fill the potential offered by the computer. Educators have tended to try to teach everyone to program computers under the name of computer literacy rather than teaching them to use the software which makes it possible for most people to use the computer.

She then encourages people to begin computer use by pointing out, "Microcomputers are like cars. You don't learn to drive one by reading about it, but you don't have to know how to overhaul the engine either. In spite of what most current 'computer literacy' courses suggest, you do not have to learn programming to operate a microcomputer. You do have to learn how to use the accelerator, the clutch and the brake, so to speak. You will have to become familiar with the kinds of software and peripherals needed to meet a particular goal. It will take more than a 10-minute test drive watching someone else to get started,

but so does driving a car. Plan for a good 2-day, hands-on user workshop to get you started. Then with the experience that comes of use, you will be able to use this machine to effectively fill your needs."

Hagen is comprehensive in her treatment; first by showing cost-effective access is possible for any disabled pupil. An appendix lists specific hardware. She recommends that an educator pick the software (programs) first, then determine which computer runs the program. She points out that most of the best software is not listed under the "Special Education" section of catalogues. For example, word processing programs, essential to most disabled children, were listed in one catalogue under "administrative management." To get the novice user started, she lists selected software, compatible microcomputer brands, and subject areas of expertise such as math or language arts. Then special education software or each disability group is indicated. She has worked with the programs and her endorsement is a true indicator of excellence.

She describes how computers can help learning disabled, blind, deaf, and physically disabled people. Many of her suggestions are novel. For instance, she discloses that disabled children should have access to databases to do research so they can learn to ask questions and get information, rather than passively answering the teacher. She recommends that they learn to use electronic mail and bulletin boards to improve their language skills. Her son uses their computer to communicate with hearing people over telephone lines, which has improved his language ability dramatically. She points to the use of word processing to help learning disabled students, imploring her readers to "remove the paper and pencil blockade."

She shows how people learn faster

when the computer drills them on facts, giving them immediate and uncomplaining feedback on whether their answer was right or wrong. Teachers can now quickly individualize instruction without having to personally sit with the student and repeat the same material over and over again. However, she cautions about the dangers of using the computer too narrowly, averring that disabled people need to do more than learn facts and remediate their handicaps. The need to develop their strengths, learn problem solving, and feel a sense of control over their environment. A chapter, devoted to LOGO (a computer language), allows the learner to instruct his computer turtle (a spot on screen) to make whatever geometric designs he may have in mind.

She is realistic and frank about computer limitations. "A microcomputer cannot love. It cannot replace a warm smile or a cuddle. This device is just a tool to add to the overall delivery system of education."

By the time the reader finishes this book, they will have a good background on computers. Although it focuses on educators, rehabilitation professionals will find a wealth of information between its pages.

Personal Computers and the Disabled by Peter A. McWilliams, Quantum Press, Doubleday & Company, 501 Franklin Avenue, Garden City, NY 11530, 1984, \$9.95.

Peter McWilliams is able-bodied, although in his book, he speaks of his reversal problems, difficulty in math, spelling, and writing, and staying "on task." All of these sound like symptoms of a learning disability. Nevertheless, he does not appear to consider himself disabled, nor does he have any known disabled members in his family. He has excellent qualifications, however, in terms of his knowledge of computers. He wrote several books on

computers, including *The Word Processing Book*, *The Personal Computer Book*, and *The Personal Computer in Business Book*. His syndicated column on computers appears all over the country. He is promoting the book far more professionally than either Bowe or Hagen, having hired a man to coordinate his speaking engagements. The topic interested him, and he was sure it would interest everyone else. The book was written for the general public about disabled people and also as a resource for disabled people.

Of the three books mentioned here, his was the most readable and interesting. His sense of humor is a plus, although a few of his jokes were in poor taste and one of them implied that physically disabled people cannot have sex. But he has a knack for making complicated concepts simple. Unlike Bowe and Hagen, he spends quite a bit of time explaining what a computer does and how it works. He has tips on how to buy a computer and a fine section on how to learn to use the machine. He describes the drawbacks to buying a computer, cautioning, for example, that "computers are powerful and therefore capable of powerful mistakes." He follows this with material on how you could train your computer not to make such errors.

His brand name buying guide included pictures of many computer systems and goes into the computer screen, printers, and keyboards in more detail than Bowe or Hagen. This is followed by information on particular systems for disabled people, which according to Harvey Lauer, (a blind rehabilitation technology specialist at the Blind Center of Veteran's Hospital in Hines, Illinois) is extremely incomplete. "What happened," Lauer explained, "was that all of his information was gotten from a certain part of the pipeline into the disabled community and he missed a lot. For example,

he didn't include many of the adaptations that blind people have made to ordinary computer systems and the excellent software developed for the Apple."

On the other hand, his resource section includes information on associations of and for disabled people, government agencies and training programs that help disabled people, government agencies and training programs that help disabled people, and programs for disabled people. This book, therefore, would be much more useful for a newly-disabled person. Bowe and Hagen are already "in the family" and assume they are teaching disabled people and professionals in

the field about computers rather than teaching people about computers and disability.

His book, published by Doubleday and Company, one of the larger presses, is being marketed to the general public and will probably be read by many people without disabilities or who have disabilities, but have no connections to the rehabilitation service system. Doubleday and Company made a business decision that the book would sell, which shows us that disabled people and their families are considered to be a market. It is intriguing that neither Bowe's nor Hagen's books were published by the specialty presses that serve the rehabilitation

community. They were published by regular publishing companies.

The success of these books may show us that disabled people are reaching full equality, particularly with the help of new technology. These books will help rehabilitation service providers learn about computers in an enjoyable and painless manner.

Dale Brown is a program manager at the President's Committee on Employment of the Handicapped. She is staff liaison to the Committee on Libraries and Information Services, which is publicizing books about disability as one of its goals.

NEWS, NOTES, ANNOUNCEMENTS

EIF Seeks Info On New Devices

The Electronic Industries Foundation of Washington, D.C. is in the midst of a 15-month Social Security Administration grant to develop and demonstrate a job placement service for Social Security Disability Insurance (SSDI) beneficiaries. The new project is based on EIF's successful Project With Industry (PWI) programs which have placed nearly 3,000 disabled people over the past 7 years.

The project is called, "Independence Through Employment." It is being implemented in 2 phases: a 3-month planning period followed by a 12-month demonstration. During the demonstration, five area programs will be initiated and will operate in conjunction with established EIF/PWI affiliated offices.

Working with the support of the state rehabilitation agency in each

area, a two-person staff will provide employment services to those SSDI beneficiaries who choose to participate. Disability beneficiaries will be made aware of the service through an outreach effort. Job placement will be provided through the PWI model, which incorporates a partnership with private industry, in the local community of the disabled person.

Wesley Geigel, formerly a career federal government employee who has held management and policy positions in a variety of programs, heads the project.

According to Geigel, its purpose is to provide SSDI beneficiaries with an alternative. "Many of these individuals would prefer a paycheck to a payment if they had access to jobs where their disability was not a factor. To those persons who wish to use the service, and can benefit from it, we'll assist them in finding a suitable job. If rehabilitation can help a beneficiary become employable, then we'll assist in arranging these services through the

state rehabilitation agency."

Along with implementing the program in the 5 areas, the project staff will also collect data on the demonstration that will be used to develop materials that will be tested by at least 15 other PWI programs to stimulate increased placement of SSDI beneficiaries.

Survey Reveals 1 In 5 People Are Mentally Ill

The most comprehensive survey of mental illness conducted to date suggests that at any given time, about 29 million Americans—nearly one in five adults—suffer psychiatric disorders ranging from mildly disabling anxiety to severe schizophrenia. But only about 20 percent sought medical treatment for their problem during the 6 months covered by the survey and those affected went mostly to general physicians rather than to mental health specialists.

The study also overturns a long-held belief that mental problems are

more common among women than among men and discloses a surprising frequency of anxiety disorders in the population, according to Dr. Darrel Regier, who headed the survey for the National Institute of Mental Health.

The \$15 million door-to-door survey of nearly 10,000 people from Baltimore, New Haven, and St. Louis provides "the first accurate assessment of the prevalence of specific mental disorder in our population," Dr. Donald MacDonald, Head of the Alcohol, Drug Abuse and Mental Health Administration, said.

Regier stated that the continuing research will ultimately include about 20,000 people—five times as many people as all previous major studies combined. From 28 to 38 percent of those surveyed reported a psychiatric disorder at some point in their lifetimes.

The types of problems reported include: anxiety disorders, such as phobias, panic disorders, and obsessive-compulsing disorders—about 8 percent of the survey and representing the most common group of psychiatric problems; abuse or dependence on drugs, 6 to 7 percent; affective or mood disorders, such as major depression and manic-depression, 6 percent; schizophrenia, the most severely disabling of mental illness, found in about 1 percent of the population. The latter can involve psychotic disturbances in thought, accompanied by withdrawn or bizarre behavior and hallucinations. Another 1 percent is affected by anti-social personality disorders.

The overall rate of these mental illness appears to be roughly the same for men and women, said Regier. But while women more commonly suffer depression and phobias, men have more problems with drug and alcohol abuse and antisocial personalities.

—*The Weekly Pulse*, Fergus Falls State Hospital, Fergus Falls, MN.

Commencement With A Difference Conducted At Cal State Univ.

Commencement exercises this year at California State University, Northridge (CSUN) will be similar to those at most colleges, yet there will be a difference. For the 22nd year, these exercises will be presented in spoken English and sign language. A sign language interpreter will translate the proceedings for 26 graduating deaf students, their deaf classmates, families, and friends. This year, 18 students will receive their B.A./B.S. and their Master's degrees.

Five hundred ten deaf students have graduated from CSUN since 1964, 316 with Master's. More than 200 deaf students each semester are mainstreamed into approximately 600 university classes with the assistance of sign language interpreters, notetakers, tutors, and counselors.

CSUN's Program of Services for the Deaf began in 1963, when a grant from the Federal Office of Vocational Rehabilitation (now RSA) created the National Leadership Training Program (NLTP) in the area of deafness. The first training class was composed of 10 hearing students who wished to provide adult education for the deaf and establish a close relationship with the deaf community.

A new dimension was added to the training program when in the next year, two deaf persons submitted applications. They met university requirements for admission and, as a result, joined eight hearing colleagues to form the first integrated class. This modest effort has developed into a dynamic program that now serves hundreds of deaf people annually.

Sign language interpreting gave deaf students full access to all university classes. But the question remained: Would fellow students and professors accept deaf students in this experimental setting? By all accounts, the answer is a resounding, "Yes." As one graduate explained, "Each time I have been asked what is the most meaningful part of the National Leadership Training program, the answer is unquestionably the same: It was the interaction of hearing impaired and hearing people sharing lives as friends, students, and professionals."

The growth in numbers of students, type of services, and levels of programs all speak eloquently for the success of the CSUN service, but no more eloquently than the graduates themselves; "Coming to Northridge was the best thing that ever happened to me . . . I had potential."

Easter Seal Magazine Celebrates 25th Year

Rehabilitation Literature, the official magazine of the National Easter Seal Society, is marking its 25th year of publication.

Its November-December 1984 edition features a symposium on "Social Science Perspectives on Vocational Rehabilitation." Joseph Stubbins, Ph.D., is its guest editor. The section explores human sciences and clinical methods, a psychological perspective of VR, ideologies of clinical and ecological models, the economist and rehabilitation, disability: the view from social policy, a political science perspective on disability, the phenomenology of disability, cross-cultural perspectives of VR in the U.S. and the United Kingdom, and VR as a social science.



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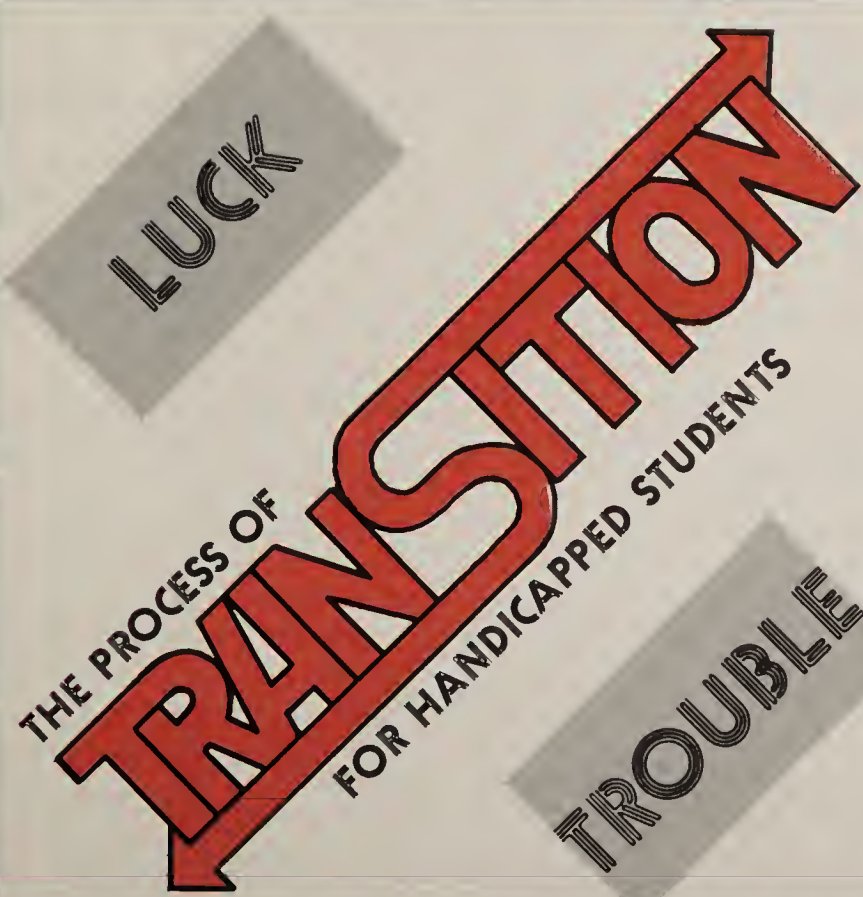
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July-Aug.-Sept. 1985

AMERICAN REHABILITATION

START HOME	Information try your luck	Peer Relations move ahead 1 space	INVOLVED FAMILY advance 2 spaces	Community Resources move ahead 1 space	SCHOOL
INVOLVED CITIZEN					Special Education No IEP trouble card
TAXPAYER					CREATIVE TEACHERS advance 1 space
IMPROVED SELF-IMAGE					Vocational Education Failed To Plan trouble card
SATISFACTION					Summer Work Experience move ahead 1 space
JOB! ADVANCE AT WILL!	HELPFUL JOB COACH advance 1 space	Job Tryout move ahead 1 space	Failed To Communicate lose 2 spaces	SUPPORTIVE COUNSELORS advance 2 spaces	AGENCY

Statement on Transition

Madeleine C. Will

Assistant Secretary
Office of Special Education and Rehabilitative Services

I am delighted that this issue of *American Rehabilitation* is being devoted to the very timely topic of transition. Because one of the major problems facing handicapped youth is the lack of a continuum of services to provide an effective bridge between school and work, transition becomes a pressing issue for disabled youth, their families, and education and service professionals. The absence of appropriate transition bridges limits our ability to maximize the productivity and independence of disabled individuals.

I firmly believe that *all* youth with disabilities enrolled in our nation's schools are capable of moving from school to employment, with the provision of necessary support services tailored to the needs of those individuals.

Transitions are an important part of

normal life. As roles, locations or relationships change, all of us must adapt, and we do so with a certain amount of disruption of stress. The transition from school to working life calls for a range of choices about career options, living arrangements, social life, and economic goals that often have life-long consequences. For individuals with disabilities, this process is often made more difficult by limitations that can be imposed by others' perceptions of disability.

Transition from school to working life is an outcome-oriented process, encompassing an array of services and experiences that lead to employment. The concept of transition should embody five separate features:

- all disabled individuals must be served;
- employment is, in fact, the outcome of successful transition for disabled individuals, as well as their non-disabled peers;
- the chronological time frame during which transition is provided is long, encompassing the high school years. Adolescence and young adult-

hood are also part of the transition process;

- transition requires coordination among multiple and relatively complex services; and

- the quality and appropriateness of each service provided under the transition umbrella is addressed.

These five facets of the Department of Education's transition concept provide a way to organize activities and improve linkages.

Several months ago, I was asked how I would know when our transition goal has been met. I responded, "As a parent, I would say when every handicapped individual has a job after high school or college. As a professional, I believe we will have achieved our goal when transition programs are institutionalized into service delivery systems."

Volume 11, Number 3 The weakest ink is better than the strongest memory. **July-Aug.-Sept. 1985**

SCHOOL-TO-WORK-TRANSITION

Cov. II	Statement on Transition	Madeleine C. Will
2	Introduction	George A. Conn
3	Interview with Sandra S. Parrino	
6	Job Accommodation Network	Jay Rochlin
9	Policies And Practices	Susan Brody Hasazi, Ed.D.
12	Supported Employment	Paul Wehman, Ph.D. Wendy Wood-Pietruski, Jane Everson, and Wendy Parent
18	The Story Of David	Ron Bourgea
21	Work-Ability	Gail Zittel
25	VR: Perspective On Transition	Patricia G. Kallsen and Susan B. Kidder

DEPARTMENTS

17 New Publications

31 Language Used

U.S. DEPARTMENT OF EDUCATION

William J. Bennett, Secretary

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

Madeleine Will, Assistant Secretary

REHABILITATION SERVICES ADMINISTRATION

George A. Conn, Commissioner

Ron Bourgea, Editor

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Cover IV for blank). Correspondence concerning paid subscriptions should be sent to Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Introduction

George A. Conn
Commissioner
Rehabilitation Services Administration

It is routine, some might say pro forma, to expect a message from the Commissioner for a Special Symposium as is found in this issue of *American Rehabilitation*. I'm sorry I can't oblige. There is no way that I as a parent of students who happen to have disabilities and as a wheelchair user and consumer advocate for most of my adult life can just give the standard introit for this issue.

The impetus for this collection of articles comes from an RSA Transition Initiative first proposed to, and accepted by, the Secretary of Education, as a Secretarial Department Goal in 1982. Later, the initiative was incorporated into the goals and objectives for OSERS by Assistant Secretary Madeleine Will.

I was charged by the Assistant Secretary with bringing together staff from special education, vocational rehabilitation, vocational education, and developmental disabilities (to name the agencies involved at the start—now we're looking beyond these to many other federal programs) to continue the momentum to improve transition services.

One point was evident from the start in our discussions: rehabilitation

staff, parents, special educators, employers, disabled people—all face the need to learn of the special contributions each can make to improving school-to-work transition for disabled

youth.

As a parent and consumer, I feel very strongly about the need for more direct, informative, useful, practical, feasible communication among the key participants in transition. But good communication is a challenge. To effect results, one must know what message one wishes to convey, and then to monitor that message to receive vital feedback.

So for this *American Rehabilitation* issue I commissioned authors to communicate their special knowledge on transition. My criteria emphasized how the message to be communicated would help parents, teachers, employers, counselors, consumers use new knowledge, now approaches, or, in some cases, "tried and true" methods, but in new settings or combinations.

I believe the collection of articles demonstrates success. I'm very pleased with the spirit, content, and even humor. RSA wants your feedback as well. Please write to let us know if the information in this symposium is helpful.

Meanwhile, we will do our best to improve transition services for all disabled youth.

1. The editor acknowledges, with gratitude, the leviathan efforts of Dr. Richard Melia of the National Institute of Handicapped Research. He was not only responsible for the planning of this special edition on transition, but consulted in every phase of its editorial process and in its production. The considerable logistics in this effort were materially lightened through his invaluable counsel and enthusiasm.

2. Also, the editor extends his appreciation to Mr. Norman Subotnik of the Administration on Developmental Disabilities, Department of Health and Human Services, for his consultation in the preparation of an article for this issue.

3. As in all editions of AR, the statements made are those of their authors. They do not necessarily reflect the policy positions of the department or its agencies.

SCHOOL TO WORK TRANSITION

An Interview With

Sandra S. Parrino
Chairperson, National Council on the Handicapped

For this special issue, *American Rehabilitation* interviewed the Chairperson of the National Council on the Handicapped. In the Rehabilitation Amendments of 1984, NCH was established as an independent federal agency and given the responsibility to advise the White House and Congress on all issues pertaining to disability, and to provide policy guidance and oversight to NIHR and OSERS. Mrs. Parrino was named Chairperson of the Council by President Reagan in 1983.

Q. When did you first become interested in disability issues?

A. Like many others who are active in this field, I am the parent of a disabled child—two, in fact. Many years ago, my son, Paul—who is now in college—was disabled at the age of one from a still undiagnosed neuromuscular condition. He is a quadriplegic in a wheel chair, and his extreme disability created a problem with his education. More recently, my husband and I discovered that our son, Alex, now 8, has a learning disability. My husband is a physician, but together we had to learn the hard way what resources are available for diagnosis, treatment, and rehabilitation.

Q. What have you done as a result

of your personal involvement with disability?

A. Basically—and this was over 20 years ago, long before the passage of P.L. 94-142—I learned that we were pretty much on our own in helping our son to get his education and to plan his life. I became very active in New York State, and was named director for the Office of the Disabled in Ossining and Briarcliff Manor, where we lived. Later, I became a member of the Westchester County Transportation Council and the Westchester Advisory Board to Group Homes for the Retarded. I was appointed to the New York State Assembly Task Force on the Disabled, which reviews pending legislation, and now I am active in Rehabilitation International, as vice president for North America, as well as being chairperson of the National Council on the Handicapped, which I consider to be a great honor, as well as a key position from which to influence our nation's public policy on disability.

Q. What issues is the council focusing on at present?

A. We are especially interested in employment, civil rights, attendant care, transportation, independent living, disincentives to employment, Social Security disability programs, and

adapting new technology to the needs of persons with disabilities. Our interest is across the board as far as types of disabilities are concerned, and our policy recommendations cut across the categories. Our council's priority at present is the development of a comprehensive Report to The President and the Congress, containing our recommendations for legislative and programmatic initiatives affecting the disabled citizens of our nation.

Q. What about transition from school to the workplace?

A. I am particularly interested in that aspect, and very pleased that Assistant Secretary Madeleine Will has made it one of OSERS' top priorities. As an advocate and as a parent, I believe we should be taking a larger view of the potential of vocational rehabilitation to improve the quality of life for all disabled Americans.

Q. How would you go about it?

A. Let's just look at the handicapped young people who are about to graduate from high school. They represent the first real "graduating class" since the passage of 94-142 10 years ago which brought handicapped kids out of the "educational closet," so to speak, and into the mainstream of the public education system.

Today, we have more than 3.5 million disabled children in public schools, grades K through 12. An estimated 60,000 graduated from high school this year. Because national policy, after years of public debate, confirmed the full civil rights of disabled children to receive their education in the mainstream public school system, their expectations have been raised that they will continue to live in the mainstream community as young adults.

These 60,000 disabled young people leaving high school now face a choice of continuing their education or finding their role in our economy and our society.

In the case of my son, Paul applied to several colleges and decided to attend the State University of New York, which is approximately 40 minutes from home. He was able to find a full time attendant who is living at the college in the dormitory with him as a roommate. At about the same time that he began college, he became a client of the New York Office of Vocational Rehabilitation, and they are paying part of the cost of his education, and part of the cost of his attendant care. We bought Paul a van, which he uses at college, and pay most of the cost of his attendant care. He is fortunate that his family was able to provide these things for him. My concern is for young people coming out of school, who don't have the money to pay for attendant care, a private van, and other needs. Many of them end up sequestered at home or in institutions or nursing homes, because their families simply cannot afford to provide support services. Imagine how an 18-year old disabled youngster would feel when entering a nursing home which will be his residence for perhaps the rest of his life!

Q. What alternative do you sug-

Inspire 1985

INSPIRE '85: An International Forum and Festival on Leisure, Sports and the Cultural Arts for Disabled Persons will be held in Washington, D.C. on Sept. 17-21.

First Lady Nancy Reagan will serve as Honorary Chairman of the events.

The forum will review progress made in the past 10 years in identifying and removing barriers which have restricted employment and recreation for the handicapped. The festival, to be held on the Capitol Mall, will celebrate the accomplishments of the disabled in games, sports, demonstrations, and exhibits.

The events are sponsored by the President's Committee on Employment of the Handicapped, People-to-People Committee on the Handicapped, and the National Council on the Handicapped.

gest?

A. I think we have to take a long look at vocational rehabilitation, to see whether it could not be restructured as part of an "entitlement" program rather than an "eligibility" program. Public school education is an entitlement, but that support ceases abruptly on graduation from high school, and leaves a very deep void in the lives of disabled young people.

Right now, public policy says employees injured on the job are *entitled* to assistance from Workmen's Compensation, and veterans are *entitled* to health and other services for service and nonservice related conditions, even long after their military duty is

over. I am suggesting that we should consider providing similar services—habilitation services—to young people who are disabled from birth or from accidents that happen before they are old enough to work. An added disadvantage to disabled students is that, if they are disabled at a young age, they have a much harder struggle to achieve an education than an adult who becomes disabled after completing his education.

We have mandated education for all disabled students, but we are not preparing all of them beyond public school. I see the need for a system where every disabled student has a chance at something—a job, more schooling—and not just those deemed eligible by vocational rehabilitation. I understand that the State-Federal Vocational Rehabilitation System accepts about one out of 10 who apply, but I am concerned about the "other 9" who are relegated to dependency-creating welfare programs. I think we would gain a lot from examining how the private sector, including insurance companies, deal with the choices between rehabilitation and paying lifetime benefits

Q. Do you believe such a suggestion is feasible, considering the limitations on public resources and the drive to reduce public spending and the national debt? Wouldn't it cost a lot of money to provide rehabilitation services to every handicapped person, and not just those who are presently able to meet the eligibility requirements of the program?

A. I don't have the answers, just the questions. But, shouldn't we consider it? If we start with the assumption that a system of entitlement can be designed to reduce the social and economic burden of the consequences of disability on society—which society is not now attending to—then I think

society has a responsibility to seriously weigh the pros and cons. Disability is on an increase because advances in medical science have enabled us to save many infants who previously wouldn't have survived their birth defects, people who have been disabled as a result of accidents who wouldn't previously have survived their injuries, and those whose illnesses previously couldn't be treated effectively. We have legislated heroic treatment and research to keep newborn babies from dying and to prolong lives, and I believe we have a concomitant responsibility for the quality of those lives which are saved.

Q. What are the pros?

A. We have long ago proven the cost-benefits of rehabilitating disabled people—the *Fortune* 500 companies are becoming interested because they see the economic advantages of training and employing disabled workers. The tax savings are significant too: It may cost \$60,000 a year to keep a mentally ill person in an institution, but only \$25,000 a year to maintain him in his own apartment with minimal services, if he or she is properly prepared for independent living. Similar savings are achieved with other disability groups.

I see a role here for the private sector. We can establish contact with every disabled student before he leaves school. Private industry, labor unions, chambers of commerce, local businessmen, independent living centers can provide career counseling and job placement. Many states have made a good start, but we need much more in the way of involvement by the private sector. Sixty thousand disabled high school graduates might seem like a large number, but divided among the 16,000 school districts in our nation, the numbers become more manageable.

Q. What are the cons?

A. Some have raised the possibility of abuse of the system, if both rehabilitation and habilitation services became entitlements. But that may be just a straw man, an excuse not to really examine this course of action.

Also, it would take a lot of money to structure a "habilitation program." But our past experience leads us to believe the long term advantages, both social and economic, would benefit the nation greatly.

Q. Are you familiar with the independent living programs, and do you believe they could be effective in addressing some of the needs which you have described?

A. I have watched the independent living programs develop from their infancy to the present point at which there are 200 or more nationwide. I believe these programs represent an important new thrust in rehabilitation services and concepts. The philosophy on which programs are based is that of consumer direction and control, which has frequently been overlooked in other, more traditional programs. I believe that when these programs begin to develop their capacity to operate efficiently and provide services to an expanded population, they will prove to be an invaluable part of the rehabilitation services continuum.

Q. Do you have any closing thoughts on how we can reach the goal of a comprehensive national rehabilitation program?

A. The question of how we reach the goal of having comprehensive medical and vocational rehabilitation services available to everyone who needs them is one to be resolved through the political process by which our nation agrees on common goals and sets public policy. But I don't think that the millions of citizens who

are disabled—and the additional millions who are their family and friends—should believe that it will happen just because it is right!

Starting the search for a solution can be a very practical step, which may ultimately lead to a new and more productive approach to fulfilling our nation's commitment to its handicapped citizens.

Behavioral Principles in Medical Rehabilitation. A Practical Guide. George W. O'Neill, Ph.D., and Russell Gardner, Jr., M.D. Charles C Thomas, Publisher, 2600 South First Street, Springfield, Illinois 62717. 312 pages. \$29.75.

Written for all health care professionals, this introductory text describes the practical application of behavior modification techniques to enhance the effectiveness of patient rehabilitation. Initially, the authors detail procedures used in behavior therapy intervention, discuss the use of reinforcement in a medical rehabilitation setting, and explain the concept of shaping, including its use with speech therapy. The elimination of such problematic behaviors as inappropriate use of the call light, verbal abuse of staff, and tantrums is then outlined, and techniques of punishment, response cost, time out, and extinction are described.

The authors also examine the behavior principle of stimulus control, the technique of fading, a method for teaching a fixed sequence of responses, the use of relaxation training, and techniques for improving compliance.

The book concludes with discussions on the contribution of behavior therapy to pain control, misconceptions about behavior therapy, and trouble shooting.

The Job Accommodation Network: A tool for Transition.

Jay Rochlin

Employment is the final objective in the transition from school to work. This, now more than ever, is an achievable goal.

Forecasts predict a shortage of qualified workers will occur in labor markets throughout the nation. For example, employers in and around Boston, in several Long Island areas, and in major cities in Texas, are already experiencing difficulty in recruiting sufficient qualified people to fill vacant positions.

Some employers are beginning to recognize that people with disabilities represent one of the most underutilized groups in the labor market today. They can be a potential resource to satisfy that labor market need. Yet many of these employers lack the knowledge or information necessary to accommodate such people in the workplace.

This concern brought a small group of business people together in September 1982, in the New York City office of D.L. (Jack) Webber, then ITT Director of Equal Opportunity Affairs. Those in attendance were members of the recently reorganized employer standing committee of the President's Committee on Employment of the Handicapped. They represented several *Fortune 500* companies as well and two small manufacturing firms.

As its first order of business, the committee began discussing ways to assist employers hire, advance, and retain people with disabilities. Reasonable accommodation was quickly identified as a major issue. Several members expressed concern that many employers either did not understand the concept of reasonable accommodation, considered the cost of accommodation to be excessive, or lacked knowledge of or access to accommodation information.

One member described a network used to share accommodation information among personnel specialists throughout his corporation. He suggested that, perhaps, a similar network could be created to enable employers throughout the nation to share information about successful job accommodations. On that fall day the Job Accommodation Network, JAN, was conceived. A network that, in its first year of online operation, has already proved a valuable resource to employers.

Development of JAN moved quickly following that initial meeting. A subcommittee sought input from other employers and from professionals in the field of rehabilitation. Many of these people provided suggestions that enhanced the original concept.

The final proposal incorporated

three concepts designed to make JAN a unique service. First, JAN would enable employers to talk with other employers about successful accommodations. The linkage would be accomplished through a computer, its database to contain accommodation information provided by employers.

Second, JAN would assume that the people requiring accommodation had the qualifications and the abilities for the job being considered and would, therefore, focus on the functional limitation(s) requiring accommodation. Employers then would learn to accommodate limitations and not disabilities by name. For example, a person with arthritis may be limited in grasping, therefore, the employer accommodates the inability to grasp, not the arthritis that caused the limitation.

Similarly, JAN would focus on functional job duties and not job titles, thereby eliminating the confusion caused by various employers using different job titles when, in fact, job duties may often be similar.

Finally, JAN would have a human interaction between the employer requesting assistance and the computer, thus adding the element of high touch to the high tech environment. The PCEH employers saw in JAN the potential for a cooperative public/private sector partnership. With pro-

posal in hand, they approached George Conn, Commissioner of the Rehabilitation Services Administration and Douglas Fenderson, then Director of the National Institute of Handicapped Research. These officials had the foresight to recognize the potential JAN presented for improving employment opportunities for people with disabilities. They agreed to help develop and implement JAN. If JAN proved successful, the PCEH employers agreed to seek funding from the private sector to support the long term operation of the network.

The PCEH employers sought an organization with adequate computer facilities and a staff knowledgeable in system design and marketing techniques to implement JAN. These resources were found at the Rehabilitation Research and Training Center at West Virginia University. On October 1, 1983, JAN was born. With funding support from the Rehabilitation Services Administration and the National Institute of Handicapped Research, PCEH awarded a contract to the West Virginia R&T Center to develop and operate the Job Accommodation Network.

The selection of the West Virginia R&T Center proved a wise choice. The center's director, Dr. Joseph Moriarty, assembled an outstanding staff that completed system design and had JAN operational within 8 months. The infant JAN took its first step on June 28, 1983, when introduced to the nation via a live telecast over the U.S. Chamber of Commerce BIZNET satellite communications system.

With the historical perspective in place, description of the network and its operation is appropriate.

The lifeblood of the JAN system is descriptions of successful accommodations contributed by employers. This information is collected by a simple, easy to use input data form. When

completed, this document describes the functional limitations and functional job duties accommodated, the resulting accommodation and, if appropriate, the source and cost. Also included is information about the employer providing the accommodation including the name and telephone number of a contact person. The JAN staff then enters this information into the database for future use.

Employers seeking accommodation information contact JAN by using a toll-free telephone number, 1-800-JAN PCEH. Calls to JAN are answered by Human Factors Consultants at the R&T Center at West Virginia University. A consultant will question each employer calling to determine the functional limitations of the applicant or employee and the functional job duties of the position being considered.

Once this information has been determined, the consultant queries the computer to identify accommodations made by other employers for similar functional limitations and job duties. This information, along with the names and telephone numbers of contact persons, is provided to the calling employer. This enables the employer to obtain additional information from other employers, that have made successful accommodations in similar situations.

If accommodation information relative to the specific need is not found in the computer, the consultant accesses other resources. This includes ABLEDATA, operated by the National Rehabilitation Information Center (NARIC) located at Catholic University, catalogs of tools, equipment and assistive devices, and contacts in public and private agencies serving people with disabilities. The Human Factors Consultants consider JAN and these other resources to be part of a larger network, the overall

objective of which is to assist employers accommodate and employ persons with disabilities. It is the consultant's objective to provide some information to every employer who calls.

At this writing, JAN has been on line for 10 months and is meeting all expectations. Employer response has been enthusiastic and growing. The baby JAN has begun to develop. Fifteen calls for accommodation information were received in its first week of operation. This has increased to a current average of 60 calls per week.

A massive marketing effort has generated additional calls from employers inquiring about JAN. The marketing campaign has included the distribution of over 17,000 information packets and 35,000 brochures, publication of articles in various magazines and journals read by employers, such as the *Wall Street Journal* and the *Harvard Business Review*. Numerous presentations have been made to employer groups by representatives of PCEH, its employer committee, and members of the JAN staff. Although employer response has been excellent, marketing will continue in an effort to reach additional employers, especially those with small businesses.

The staff has already begun to improve the usefulness of the system. JAN output abstracts now carry a notation advising employers of possible eligibility for tax credits. It directs them to contact either the local vocational rehabilitation or IRS office for information.

A listing of all state VR offices is being added to the database. When completed, this will enable the JAN consultant to provide employers with a link to local resources.

The employer base has been expanded to include the nation's largest employer, the federal government. A recent memorandum from the Executive Secretary of the Inter-Agency

Committee on Handicapped Employees to Selective Placement Coordinators and Handicapped Program Managers recommended full use and support of JAN.

Other enhancements being considered include using JAN for research. It has the potential to provide detailed data about accommodations. For example, research into the type, cost, frequency and effect of accommodations could prove useful in encouraging employers to accommodate persons with disabilities or legislators to support the rehabilitation system.

The value of JAN to employers is not limited to the initial employment process. JAN assists employers provide career mobility to employees who are disabled and return-to-work employees who became disabled. The latter issue becoming a major concern to employers as health insurance and benefit costs skyrocket.

JAN can also be a useful tool to the rehabilitation practitioner. State agency personnel can use JAN to get employers involved in the placement process. Rehabilitation specialists should encourage employers to call JAN to obtain accommodation information. Employers who participate in the process often have a stronger commitment to the outcome. The rehabilitation specialist can offer to be an on-site consultant to employers to interpret and implement the information received from JAN. Such an approach can strengthen the relationship between business and rehabilitation.

JAN has proved to have a positive impact on employer attitudes. Some employers calling JAN for information are surprised to learn that other employers have already made accommodations in similar circumstances. They quickly realize they are not the first to face the problem and that the solution is often not a "big deal."

Sometimes skepticism characterizes

Employment Goal Raises Questions For Everyone

The . . . approach to transition asks a great deal of educators, employers, parents, students, and rehabilitation staff. When the transition plan for a severely physically handicapped student starts with the assumption that employment is the goal, and that success will be measured long after graduation based on the appropriateness of the job obtained, many questions arise. What work experiences will be provided during school? Who will advocate for the student, provide the exposure to work? How are needs to be met for residential placement, income support, transportation, medical needs, insurance? Who will develop the jobs and modify the tasks so that the individual with limited functional capacity can perform them?

The disabled students themselves are not the only people experiencing new role transitions. Their teachers, rehabilitation counselors, vocational evaluators, job analysis specialists, and employers are also being asked to "transform" their roles. They must make a transition to new ideas and methods of implementing them. For some there will be new concepts with a new vocabulary to learn about, such as work experience, shadowing, mentor programs, cooperative education, job analysis, task analysis, job coaching, staff fading, job restructuring, rehabilitation engineering, job accommodation, transitional employment, and supported employment.

—Richard P. Melia, Ph.D., reprinted from "Transition Services For High Functioning Physically Disabled Students," *PRISE reporter*, King of Prussia, PA.

the attitude of employers who call. Yet, this attitude very often changes to one of support because of the experience with JAN. Such was the case of one employment manager who called concerning placement of a new applicant. The person in question was the best qualified among 300 professionals who applied for the job. However, he had a mobility impairment and used a wheelchair. Local supervisors were concerned about accommodations and quite reluctant to offer employment, even considering the applicant's qualifications. That all changed after calling JAN. The information the employment manager received enabled him to convince local supervisors about the applicant's ability to perform the job given the necessary

accommodations. As a result, the company obtained the services of the best qualified candidate whose subsequent performance as an employee has left no doubt about the correctness of the decision.

As the young JAN matures and grows into adulthood, its future is unlimited. Given the positive support of employers and rehabilitation professionals, JAN will continue to have a significant impact on employment opportunities for people with disabilities, thereby easing the transition into the nation's workforce.

Mr. Rochlin is Executive Assistant to the Chairman, President's Committee on Employment of the Handicapped on executive loan from AT&T.

Facilitating Transition From High School: Policies and Practices

Susan Brody Hasazi, Ed.D.

Current literature and best practice are increasingly defining transition from school to adult life as that period which encompasses high school, the point of graduation, and the initial years following graduation. This definition is somewhat different from more traditional views which emphasize the specialized linking services between school and the opportunities available in the adult world. This expanded definition of transition services implies a collaborative, systematic approach to the planning, implementation, and evaluation of a range of educational and rehabilitation services.

The purpose of this article is to describe a variety of policies and practices related to program organization, curriculum, and vocational experiences which can be implemented during the high school phase of the transition process. Although the activities are initiated for the most part by school personnel, many require collaboration with and services from rehabilitation and other social service agencies.

Local Interagency Agreements

A secondary level program with employment or postsecondary education and training as one of its primary goals requires the use of

resources from both generic and specialized services. An excellent mechanism for identifying human and financial resources is the development of local interagency agreements (LIA) between vocational education, special education, vocational rehabilitation, developmental disabilities, and employment and training agencies. Such agreements should specify the services provided by each agency; the conditions under which referrals can be made; provisions for development and delivery of jointly sponsored inservice training for professionals across agencies; and procedures for monitoring, evaluating, and revising the LIA. In formulating the LIA, particular attention should be directed toward including generic agencies or programs, such as community colleges and state employment and training services.

A recent followup study of handicapped youth in Vermont who left or graduated from high school between 1979 and 1983 indicated that 35 percent of handicapped youth independently contacted generic employment service agencies, probably because they were familiar with them through family members and friends.² However, these youth often reported that they were not able to secure jobs or training through

these agencies. This suggests that a LIA might consider a provision for placing specialized personnel (such as a vocational rehabilitation counselor) in local employment and training offices to assist in the evaluation of client needs and the identification of appropriate services.

Transition Plans

Transition plans for individual students should be developed as components of the individual education program (IEP) and the individual written rehabilitation plan (IWRP). Transition components of both plans should be written when the student enters high school, or sooner if necessary.

As integral components of the IEP and IWRP, transition plans will identify residential, vocational, and other goals necessary for living as independently as possible following graduation from high school. In addition, the services needed to achieve the goals, the names of the people from various agencies who will be engaging in activities to achieve the goals and timelines for completion should be described. Transition plans should be reviewed at least twice a year and revised, as necessary. At least 18 months prior to graduation, the adult services which will be required

following graduation should be identified and the appropriate agencies included in the planning process. Although the transition plan will probably be initiated by school personnel, continuous monitoring and identification and coordination of resources will be necessary for some students following graduation. In many cases, particularly for those youths who require time-limited postsecondary services, vocational rehabilitation will be the agency with primary responsibility for the delivery of services.

A key aspect in the development of the transition plan is inclusion of the student and parent or guardian in identifying long-range goals and valued activities. Students and parents can often provide information about skills and interests that is not readily observable through interactions in school environments. Further, through involving the students and parents in the process at an early stage, issues related to future living situations, as well as vocational aspirations, can be clarified.

Often, the resources needed to insure the achievement of long-range living and employment goals may not be available. Parents and students themselves, if given time and information, are in the best position to advocate for the needed services.

Youth Find

A provision of the Carl D. Perkins Vocational Education Act of 1984 will greatly enhance the identification of school-age youth with handicaps in need of vocational education and training. This provision (Title II, Part A, Sec. 204) requires that all handicapped students and their parents be informed of the opportunities available in vocational education no later than ninth grade. Recently many parents, students, and

special educators were not aware of the programs provided by vocational education or that handicapped youth were entitled to participate in the programs. Given this new requirement, it is likely that vocational and special educators will engage in increased planning and hopefully learn more about each others' resources. In any case, handicapped students and their families will have additional information regarding vocational education and training options and will be more likely to ask questions regarding vocational objectives at an earlier age. This, in turn, should provide an incentive for special and vocational educators to use resources such as vocational rehabilitation to assist in the delivery of vocational instruction.

In addition, PL98-199 (Education of the Handicapped Act Amendments of 1983) requires that state education agencies annually collect information on the number of handicapped children and youth who exit school by disability category, age, and the services which will be needed for the following year. This provision will facilitate another opportunity for collaboration between special educators and vocational rehabilitation professionals. In order to supply the required information, special educators will need to work with rehabilitation and social services agencies.

Curriculum

Over the past few years, secondary special and regular educators have been developing program options which are characterized by increased opportunities for interaction with nonhandicapped peers, community-based instruction, and curriculum designed to teach skills needed in the adult world.^{3,4,5} Given these

directions, there are many ways that vocational educators can work together.

First, with increased numbers of handicapped students participating in mainstream vocational education classes, there is a need for adaptation of equipment and environments.⁶ Many vocational educators could provide excellent instruction in specific occupational areas if they had assistance in rearranging the classroom and in modifying equipment. Our followup study in Vermont showed that those handicapped youth who participated in mainstream vocational classes were more likely to be employed following graduation than those who did not.⁷ Given this finding, it would seem that the combined resources of vocational rehabilitation and special education should be directed at increasing the numbers of handicapped students who participate in mainstream vocational education in order to decrease the numbers of handicapped students who need vocational rehabilitation services following high school.

A second area of collaboration in curriculum involves the teaching of job-seeking skills. Our followup study revealed that 84 percent of former special education students who were employed found their jobs through the self-family-friend network.⁸ This finding is consistent with other studies of nondisabled and disadvantaged adults who reported that the most frequently used method of finding a job was also through the self-family-friend network.⁹

A number of curriculum programs have been developed which capitalize on using the self-family-friend network for job seeking. Azrin and Besalel's, *Job Club Counselor's Manual*,¹⁰ is a systematic, structured approach to teaching job search skills,

such as identifying and contacting potential employers and resume preparation. This program can be adapted for use by students with severe deficits in both reading and written expression. Students can work in pairs (*e.g.*, a student who is skilled in reading with one who is not) while the teacher provides information could be shared by a special educator and a vocational rehabilitation counselor. This activity would provide an excellent opportunity for a vocational rehabilitation counselor to teach job seeking skills that could be independently used again by students seeking their second or third jobs.

Vocational Experiences

Since many handicapped students have not had the opportunity to explore and identify potential areas of vocational interest and skills prior to high school, it is important for secondary programs to provide a variety of work experiences to assess both interests and skills. These experiences should be offered in the community in areas with employment potential and with contingencies that replicate real employment expectations to the greatest degree possible. At least 4 such experiences from 3 to 6 months in duration should be provided between the ages of 15 to 18. The followup research¹¹ indicated that handicapped students who had "real" jobs during high school were more likely to be employed following graduation than those who did not. Interestingly, this finding was consistent across all disabilities and levels of severity. This suggests that regardless of the handicapping condition, if a student does not choose to enroll in post-secondary education or training following high school, the goal of the secondary program should be placement in competitive or supported work during the last year of

school.

In order to provide handicapped students with quality community-based vocational education and training during high school, the job responsibilities of special educators and vocational rehabilitation counselors may need to change. Some secondary special educators will spend more time in the community training and supervising students at job sites. This may mean that working hours vary, depending on the jobs at which students are working. Some teachers may work from 7:00 a.m. to 3:00 p.m. while others may work from 4:00 p.m. to 10:00 p.m. Vocational rehabilitation counselors will work closely with school personnel on job development, job analysis, and job placement activities for students at relatively young ages. This may necessitate the placement of vocational rehabilitation counselors in the schools or assignment of counselors to specific schools. In addition, counselors could assist in the training of professional and paraprofessionals who will provide supervision and followup to students in competitive or supported work sites.

Followup Measures

There is a critical need to acquire information on the employment and residential status and use of generic and specialized services by handicapped youth following graduation from high school. Currently, no agency has the fixed responsibility for gathering these data. Since every handicapped student with an IEP is part of the special education system, it would seem appropriate for special educators to collect information on their former students. Data regarding the relationship of high school education and training experiences to present

employment and information related to community and personal characteristics are essential in order to evaluate the appropriateness of curriculum and experiences offered during high school.

Vocational rehabilitation agencies could be extremely helpful in this regard by routinely informing school personnel of former students who are referred for services through means other than the school.

Conclusion

Implementation of the policies and practices discussed above will have an impact on the roles and responsibilities of special and vocational educators, as well as rehabilitation and other human service professionals. The goals and organizational structure of secondary-level special education will also change. The technology for achieving these changes is available. What is currently needed is a commitment by policymakers, educators, and human service providers to combine resources, both human and financial, in ways that facilitate increased opportunities for vocational training and employment for people with handicaps.

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(Continued on page 16.)

A Supported Employment Approach To Transition

Paul Wehman, Ph.D., Wendy Wood-Pietruski,
Jane Everson, and Wendy Parent

The concept of transition from school to adult life for youth with disabilities is not new.^{1 2} However, the recent initiatives by the U.S. Department of Education, Office of Special Education and Rehabilitative Services and the Administration on Developmental Disabilities in the Department of Health and Human Services have again closely focused attention on what happens to disabled youth who "age-out" of special education. Many federal research, demonstration, and training grants are being funded in this area as well, especially with the impetus of the Secondary Education and Transition Services provision of Public Law 98-199, the Education Act Amendments for Handicapped Children. Furthermore, one state, Massachusetts, has gone so far as to enact legislation (Public Law 688) to establish a Bureau of Transitional Services which oversees the coordinated movement of disabled youth to meaningful adult services.

What makes these initiatives truly exciting is the efforts at channeling students to move directly from school into quality employment. Since the signing of the Education for Handicapped Children Act in 1975, over half of a generation of special education students have finished school resulting in an almost crushing demand for

services from vocational rehabilitation and other adult service providers. This law mandated services for *all* handicapped children regardless of severity of handicap. Now, thousands of truly severely handicapped youth are looking for adult services.³ What is especially challenging is that these students and their parents not only want services, but they want meaningful employment with decent wages.

It is clear that while there has been almost a tenfold increase over the past 15 years of adult day service programs⁴ and similar increases in the number of sheltered workshops, that neither the quantity nor the quality of this activity is going to be acceptable to many severely disabled consumers. What is necessary is the construction of a variety of *transitional* and *supported employment* alternatives for youth to choose from as they leave school. Industry-based enclaves or work stations in industry;⁵ job coaches for transitional and supported competitive employment;^{6 7} and small business-like specialized training programs which are highly integrated into the community⁸ are but some of the types of options which will need to be developed.

Students with severe disabilities tend to experience higher unemployment rates than those with mild dis-

abilities.^{9 10} Supported employment, however, may be an excellent alternative for improving employment options for those with severe disabilities. Supported employment is defined as: "On-going intensive service required for individuals with severe disabilities to gain and maintain employment in regular work settings. . ." *Federal Register*, Feb. 28, 1985.

We believe there is a strong linkage between the school-to-work transition of severely disabled youth and supported employment. Specifically these students cannot usually gain employment with traditional time-limited services. Supported employment is a vehicle which can make transition meaningful. It is not limited to those persons with mental retardation but can be effectively used with severely physically disabled youth, those with serious emotional disorders or students with multiple sensory or physical impairments. The most functional assumption of severe impairment which we are using is that disabled people could not gain or maintain employment without *permanent* ongoing support.

To this end, our paper presents key concepts in designing an individualized plan for transition, and two programmatic examples of how a supported work approach to competitive

employment can work. Each example is with persons with mental retardation who work in service occupations.

Developing A transition Plan: The Educator's Perspective

A formal transition planning procedure should be implemented for all students with severe handicaps, by at least age 16. To be effective, transition planning should be individualized, developed cooperatively by school and adult services agencies, and outcome oriented.

Individualized Transition Planning

Since the school service system is the agency serving students with disabilities at age 16, it is the school or the local education agency (LEA) that should initiate transition planning. To individualize the transition planning, the Individualized Educational Program (IEP) planning meeting which is scheduled once each year for all students receiving special education is the natural mechanism for developing an individualized transition plan. Thus, starting at age 16, the IEP meeting should become a *Transitional* IEP meeting that focuses on post-school outcomes, especially employment and independent living. The IEP will set the transitional goals and objectives as the primary focus for programing within the school service delivery. If transitional goals and objectives are developed separately and not included in the IEP, it is less likely that they will receive attention in daily programing activities.

Interagency Cooperation And Participation

The transitional IEP meeting should include the student; the parent, guardians or primary caretakers; representatives from the school program such as the special education teacher, the vocational education teacher, the

occupational and/or physical therapist, the speech or language therapist, etc.; and representatives from the adult service agencies, such as the vocational rehabilitation counselor, the community service board (CSB) case manager, a residential services counselor, etc. Each of these has an important transition role to play.

The *student* should always be present when employment is a possible objective. The student should be asked if he/she wants to "have a job" after graduation. If yes, then the student should be questioned on what type of job is desired.

The *parents or guardians* play a critical role in the transition process. The success of any transition plan will ultimately depend upon their support. Some nonemployment outcomes of mentally retarded people, for example, are directly attributable to the lack of parental support.¹¹ Parents should be asked what they want for their children. Parents who have low expectations for their child will probably want and expect sheltered employment. Starting the transition planning at age 16 will allow time to raise parent's expectations beyond sheltered employment.

The *school representatives* will bring experience with the student to the transition meeting. Their recommendations will help identify potential for employment and independent living.

When a curriculum includes integrated and community based training and employment opportunities, students will have greater options for employment after "graduation."¹²

School representative should discuss the post-school options which best meet the wants, needs, and capabilities of the student. The vocational teacher may identify a part or full time job as a dish machine operator in a food service position. For the student

to succeed, teacher may feel that a job coach will be needed for the initial 3 to 5 weeks on the job. This should be discussed at the IEP meeting.

Adult service representatives from the local community who will most likely be serving the student after school should participate in the Transitional IEP meeting.¹³ If employment is a desirable outcome, the vocational rehabilitation counselor should be present. The services of a case manager should always be involved whether or not the student will work after graduation. Services representatives will be able to provide valuable information on adult services available and attainable during the transition period. When both school and adult service systems are represented, plans can be developed which provide for appropriate and uninterrupted services.

Outcome Oriented Transition Plans

The major difference between a traditional IEP planning meeting and a Transitional IEP planning meeting is in the development of goals and objectives. The typical IEP develops goals and objectives for the coming school year based on goals and objectives which have been mastered in the current school year. This process is not a developmental approach because specific educational goals and objectives targeted may not be relevant for the student in post-school life. In a Transitional IEP meeting, the goals and objectives address outcomes for the student to achieve as an adult. Developing outcome oriented goals and objectives require asking the right questions: "What is the employment in the targeted position?" "Who is responsible for implementing each of the steps?" Timelines should be set for the intermediate objectives. An example of a Transitional IEP annual goal might be:

- Student will be competitively employed in a part-time (20-25 hours/week) food service position by May 1986.

Some intermediate objectives for this transition goal might be:

- Five advertised positions for food service personnel will be applied for by April 1986. Person responsible: vocational education teacher.

- Student will ride public transportation to and from employment independently after 1 month of transportation training. Person responsible: special education teacher.

- Student will perform job duties with 80 percent accuracy by June 1986 given 1 1/2 months of job site training services. Persons responsible: vocational education teacher and special education teacher.

- Student will perform job duties with 95 percent accuracy by August 1986, given job site training provided by a job coach (job coach services to be purchased for summer months). Person responsible: vocational rehabilitation counselor.

- Student will retain employment position indefinitely given follow-along and maintenance support services by CSB. Person responsible: CSB case manager.

Illustrations of Competence

Case I: Michael. He is a 22-year old student in his last year of school in a special education school, attended since he was 6 years old. Psychologists have assessed him as having moderate to severe mental retardation (IQ 26-51), according to standardized intelligence tests. Medical records report no significant sensory, perceptual, or motor problems, but a history of epilepsy, successfully controlled by medication for 3 years. School records indicate that his speech is clear, and he interacts minimally with others using short, incomplete sentences. He has

acquired simple counting skills, basic word recognition skills, some coin discrimination, and can tell time to the hour. He has a history of aggressive behavior. His family is supportive and encourages him to interact with non-handicapped peers and to use the public bus system.

Michael has participated for 3 years in a community-based vocational training program through his school. Three days a week, he and four other students practice janitorial skills at a local business under the supervision of their special education teacher. Major responsibilities include buffing, mopping, dusting, vacuuming, and emptying trash. His teacher describes him as a slow, steady worker who can complete up to three tasks independently with minimal supervision and reinforcement.

At age 21, Michael was referred to the VR agency for employment services by his special education teacher. The rehabilitation counselor arranged for supported employment services. A job coach met with him, his special education teacher, vocational teacher, rehabilitation counselor, and family to discuss specific vocational goals and employment options. They decided that a part-time job that used his janitorial skills would be an appropri-

ate job outcome.

Michael was hired as a maintenance worker in a department store for 20 hours a week at a salary of \$3.35 an hour, plus employee benefits that included medical, dental, vacation, sick leave, and an employee discount. His job consisted of vacuuming the rugs in 9 departments, 4 days a week and, once a week, to move the clothing fixtures and vacuum underneath them.

Before placement, his job coach learned the job and developed a task analysis for training. The coach also established the coworkers' production rates and planned strategies for increasing Michael's production rate. School and transportation arrangement were made.

Each day, his job coach accompanied him to provide training, support, and as a model for interactions with coworkers and customers. Training and production data were recorded daily. Michael had difficulty generalizing his previous training to a new environment. Because he was easily distracted and failed to check the clock, he often did not complete the job or take his break at the appropriate time. The coach developed a work schedule based on the average time needed by Michael, the coach, and his coworkers to complete the job. The schedule helped Michael to take his break and leave work after he had completed designated sections of work. If production rates were maintained, he would finish in time to take a break with his coworkers and leave in time to stop at a fast food restaurant for lunch before catching the bus back to school.

By the end of 4 weeks, he was completing the job with 95 to 100 percent accuracy and maintaining the sufficient competitive speed to satisfy his supervisor. The coach gradually reduced training time but continued providing reinforcement, collecting data, and



supervising. Eventually the coach reduced time spent to followup visits. In 3 months, Michael's salary was raised to \$3.60 an hour and his supervisor reported that his work was "better than required."

Michael's teacher and family described him as more social and mature. Additionally, he interacts with his nonhandicapped peers more frequently, participates in more community activities, and independently initiates grooming. Michael has learned to cash his paycheck, and voluntarily offers to contribute a portion of his salary toward family expenses. He purchases clothing, records, and food with the remainder of his money. His teachers report that he is envied and admired by his peers whom he frequently advises about the role of a working adult. His job coach, rehabilitation counselor, special education teacher, and family continue to provide support and to plan for independent living as he prepares to leave school.

Case II: Kathy. She is a 21-year old student with Down's Syndrome who is finishing her final year of public school in a self-contained class for students labeled "trainable mentally retarded." She spends most of her school day learning pre-academic and pre-vocational skills and has minimal interaction with her nondisabled peers or with her community. Kathy speaks in short sentences, but her speech is difficult to understand for people who do not know her well. She has no significant medical, academic, or psychological problems, other than obesity. Her teacher and family report that she is independent in many self-care skills, but often needs prompting to initiate and complete routines. Her teacher describes her as "stubborn and often flirtatious."

During her last year of school, Kathy was referred for supported em-



ployment services offered by her school system. At a transitional IEP meeting, Kathy, her special education teacher, vocational rehabilitation counselor, parents, and job coach targeted a part-time position in a fast food restaurant near home. Because of no previous vocational training, the job coach spent a great deal of time assessing her work skills and her related vocational skills to ensure an appropriate job match. Her family was hesitant and required reassurance by the job coach that Kathy would not lose her social security benefits and would receive continued support while employed.

The coach identified a "crew member" position at a fast food restaurant near home and school. The coach spent several days task analyzing the position and developing a strategy for training before employment. The coach also targeted bus training. Kathy was hired to work 5 days a week, for a total of 30 hours. Her salary is \$3.50 an hour without benefits because she is a part-time worker.

During the first month, her coach accompanied her to work every day, assisting in completing nearly 90 percent of the job, which included bus-ing, washing, and drying food trays and emptying the trash. The job coach used verbal, model, and in some instances, physical prompting to train her. He designed a series of picture cue cards to help follow her schedule to complete her work and take a break appropriately.

The job coach, in cooperation with her family, trained Kathy on indepen-

dent grooming skills. She is learning to interact with her coworkers during her break and they, in turn, are learning how to interact with her. In addition, her coach is modeling appropriate social skills so that she is learning to politely respond and interact with the restaurant's customers.

Gradually, over 2 months, Kathy's job coach reduced the intervention time. She is now able to complete almost 60 percent of her job and is able to ride the bus to and from work with minimal assistance. The coach still accompanies her at work, but now spends more time observing and collecting production data than actually assisting in completing the job.

Kathy has received favorable evaluations from her supervisor who was at first reluctant to hire a person with a severe disability. Through the use of the supported work model, Kathy is quickly becoming a productive employee.

Summary

The purpose of this paper has been to present the role of special education in promoting community-based vocational instruction, transition planning, and competitive employment. A major section outlines how to develop Individual Transition Plans for handicapped youth who are soon to leave special education. Two case studies were presented of significantly mentally retarded persons who would typically be at high risk of becoming employed because of the severity of their handicap. Each case study described how a supported work approach to competitive employment was used. This approach is based on seven years of work in Virginia using this model.¹⁴ It should also be noted that vocational rehabilitation played a major role in making these successful transitions occur through referral, case management, and purchase of service.

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PUBLICATIONS & FILMS

Social Influences In Rehabilitation Planning: Blueprint For The 21st Century. Gary F. Austin and Leonard Perlman, editors. Switzer Memorial Fund, National Rehabilitation Association, 633 S. Washington Street, Alexandria, VA 22314. \$12.

This is the proceedings of the Ninth Switzer Memorial Seminar in Rehabilitation held in New York City in November 1984 and cohosted by NYU Department of Rehabilitation Counseling and the Human Resources Center of Albertson New York.

The 100 pages contain 5 chapters and 6 special papers that include such topics as ethical considerations facing society in rehabilitation planning; the politics of disability; changing perceptions of disability; trends and the demographics of disability in America. Also included are recommendations and implications for action for service delivery, legislation, research, policy development and training. The comments and ideas of the 20 Switzer Scholars are found throughout the text.

The monograph is intended for use by rehabilitation practitioners, policy makers, legislators, researchers, and educators interested in matters of disability and rehabilitation.

Complete Guide to Employing Persons With Disabilities. Henry McCarthy, editor. Human Resources Center, I.U. Willets Road, Albertson, NY 11507. \$9.95 plus \$2.25 handling. 256 pages.

This is a reference manual for managers involved with implementing corporate programs of equal employment opportunity for handicapped people. It is based on the premise that the affirmative action principles and procedures established by the Rehabilita-

tion Act of 1973 represent not only legal requirements but also basic policies of sound personnel management.

Part I answers the "why" of EEO by presenting a state-of-the-art summary of issues and regulations affecting individual and corporate commitment to affirmative action. Part II explains the "how" of affirmative action programing. Part III discusses significant resources that would lend support and assistance to the development of the type of affirmative action programing recommended in the first two sections.

Included is an annotated bibliography of print and audiovisual resources on employment of persons with disabilities.

Career Education For Handicapped Individuals. (Second Edition) Charles J. Kokaska and Donn E. Brolin. Charles E. Merrill Publishing Co., Columbus, Ohio 43216. 454 pages. \$26.95.

From the book's "Preface": "This book presents career education as a whole life process for all handicapped individuals regardless of how they are categorized or labeled. We see career education as a sequence of planned learning activities that prepare individuals to participate in various occupational, avocational, family, civic, and retirement roles. We examine all career development needs and provide a mix of daily living, personal-social, and occupational activities for elementary students through adults."

Its 13 chapters are divided into three sections that address such areas as daily living, personal-social, and occupational skills; contributions of business and industry; educational planning; career and vocational as-

essment; and the final section on issues and future directions. The book is indexed and contains references as well as several appendices.

Creative Change. A cognitive-humanistic approach to social work practice. Howard Goldstein, editor. Methuen, 733 Third Avenue, New York, NY 100017. \$14.95.

The book sets forth a common-sense approach to social work with a range of individual, family, and group problems of living.

The various chapters illustrate ways of unraveling and working with problems of the abusive family, the battered woman, the alcoholic, the mental patients in the hospital and the community, the chronically ill and dying patient, the self-help group, the rural poor, and the Vietnam veteran.

In his summation of the book, editor Goldstein writes "... cognitive-humanism offers few recipes or instructions about what to do or when to do it. To be sure, there are many useful generalities and broad theories that offer some outlines for comprehending a nominal problem area; yet, each specific human event must be understood on its own ground at its particular moment in time. . . ."

"When the notions of formula, prescription, or system are subtracted, what is left in the concept of a cognitive-humanistic orientation to practice? What is left, to start with, is an unpretentious way of working with other human beings as colleagues and not as experts. The primary intent is to enter into and attempt to fathom the subjective world of our client; it is in that realm that we can, with some humility, begin to appreciate what is of consequence and value to that individual as well as the kinds of beliefs and ways of thinking that both aid and detract from his or her well-being and worth. . . ."

Confessions of a Father

The Story of David

Ron Bourgea

David was 8-years old and, after the birth of three daughters, the doting pride of perhaps an overindulgent father but, also, the considerable concern of the family's older distaff majority. The almost certain knowledge that David would "round-out" our family unit contributed significantly to his importance in the hierarchy. We could look forward to a normal progression of growing, teenage concerns, and eventual aggrandizement of the family unit through professional endeavors and through marriage.

Until that fateful day in his 8th year of his diagnosis as a juvenile diabetic, we were quite oblivious to medical catastrophe. This in spite of my having served in the Hospital Corps of the U.S. Navy for 20 years and my subsequent pursuits in mufti as an editor in the Vocational Rehabilitation Administration (now the Rehabilitation Services Administration).

Although I was familiar through my editorial work to the black pall that obliterates hope in the family when such an announcement is made, I was woefully unprepared for its consequences. The girls were no less affected, as we went through the typical

stages of denial, guilt, and anger. My reaction was: "Why him, Lord? Pass the cup to me!"

The answer to that plea, I was to learn, is not instantaneous, but parceled in cryptic packages over an expanse of time. We were to learn, through frustration, that the impact of the announcement "diabetes" was the least significant in the process of maturation. We were to learn by trial and error, of good intentions but bad advice, of false hope and truthful reality, of the disease's meaning in his life and of its effect on our lives.

Our military doctor impressed on us the importance of diet and, so, arranged a meeting with a dietician. We reviewed the different food classifications and learned of substitutions: lettuce, for example, was a vegetable that was allowed in abundance, but corn was not at all a vegetable, but a "bread," one of the more restricted items on the menu of a diabetic. By the same token, peanuts were not "breads" but "fats," another of the restricted items. We mastered the intricacies of what was what and what could be substituted and not substituted for what.

An overall, guiding diet was developed that listed allowable portions of "breads," "meats," and "fats" in particular and cautioned against certain vegetables and fruits. Specific food choices were made within the constraints of that guiding diet. I launched into an enthusiastic and (I thought) innovative charting of food variations allowable. I could but

barely attune my enthusiasm to David's aversion to this regimentation. The sight of the "postage scale" which we had purchased to weigh his "meats" became intolerable to him. We adjusted by "eyeballing" the meat portions. Nonetheless, the contrast of our "full portions" as compared to his "metered amount" remained a hostile point of contention. Misguided efforts at explanations soon turned to pleas for his good health and, eventually, degenerated into authoritarian command. (Ten shelled peanuts in place of an ice cream cone cannot be rationally explained in health terms to an 8-year old!)

But our concern for good health could not attenuate his rejection at any point on the continuum. The approach at any point may have been justified on our part, but, on his, was an insufferable intrusion on "normalcy." He would have none of it! We suspected that he was "sneaking" food. The thought was upsetting as I envisioned his going into a coma which we had been cautioned about.

My wife suggested that we join a diabetic group, that we speak to the parents of other diabetic children. I was adamant. "No!" (While I had accepted David's condition, I viewed it as our problem, a family affair. We'd always handled our problems within the family. So should that be the guide here!) In hind sight, of course, I see the colossal mistake that this impervious stand perpetrated on our mental health and of the tacit unfairness to my son whom I professed to love so fully. Although the solution was never broached, I should today not hesitate an instant to seek the company of other parents who might shed some comfort and information in the rearing of a diabetic child. The error was grievous, but committed however misguided.

Certainly, David himself could have

benefitted from these associations and, of even more importance, from the counseling of a professional person. Although he received some counseling from his doctor, these sessions were sparse and intensified in the medical area rather than the psychological support that was needed, as well. His dilemma of avowal to his peers, for example, ran the gamut from disavowal (with its consequential disregard of medical advice and episodes of defiance, revolt, and near catastrophe) to a cavalier "sideshow" of inviting his friends over "to see him shoot up" his insulin. Again, my intransigence was at fault! The eventual extrication from this era in our lives suggests a providence that should not be so gentle to the foolhardy.

In time and after being buffeted by the psychological storms of this and other aspects of David's condition, I did seek the guidance of a physician. I say "a physician" since David was seen at a naval hospital and the impermanence of military assignments being what they are perpetuated a profusion of physicians to our lists. His advice, at any rate, was that David must "learn to handle his own disease," that he must be "allowed to learn from his own mistakes."

I was appalled! Earlier I had been told that David's life was on the line. The dire results of faulting diet or insulin regimen was impressed on me. Now, suddenly, the rules had changed. Previously, the physician would consult with the family. Now it was private sessions with David. The "feedback" became less and less from either David or his doctor. Imperfectly, perhaps, but inexorably, David assumed the control of his own life. While the "terror" on my part never abated, the decision was wise, if, I believe, having been made with a poor transition for parental concern. Although I dimly understood this wis-

dom, I was unprepared to forsake the reins of his care so suddenly. I felt betrayed and rejected. That poor understanding only led to more confrontation, acrimony, and loggerheads.

This kind of documentation can be chronicled for myriad aspects of the perniciousness of the incipience of diabetes on his and our lives: the regulation of insulin, the problems of avowal or denial to his peers and ours (which I alluded to above), the intrusion on family life of contingency planning for almost every occasion, his sometimes stormy relationships with his sisters and their resentments when we ostensibly "took his side," and many more aspects of the altered lifestyle that his disease perpetrated in the conduct of our and his affairs.

If we were to know family disruption because of dietary and medical care, those attendant to school life were no less froth with controversy and confrontation. Based on our physician's admonition that we must always take seriously David's announcements that he was on the brink of an insulin reaction, we imparted this injunction to his school's officials. What we didn't know until much later was that David had found a useful subterfuge in avoiding whatever subjects displeased him or caused him any amount of consternation. By simply pleading an insulin reaction, he would be excused from class.

The school nurse had his orange juice and provided a resting place which, with time, really became a "nesting" place. Eventually, the periods became more frequent, but we were ignorant of their frequency and their deleterious effect on his scholarship. We had falsely assumed that passing grades meant that he was attaining at a commensurate level with his peers.

The habit was escalated from an occasional class to classes, and, finally,

to whole days where, ostensibly, David was under "medical care." The crisis finally came when we were advised that he had not been to class for nearly 2 months! Needless to say, the ensuing investigation was convulsed with acrimony and accusation, with the shattering of icons on all sides, with strategic maneuvers and counter stratagems. The process was physically demanding and emotionally draining. My tactics with David ran the gamut, from rational exposition, to pleading, to commanding. The maneuvers included our delivering him to school and picking him up in the afternoon (portal to portal) and having a class-by-class attendance record delivered (where each of his several teachers signed him in and out of their classes). We even contemplated the next-to-impossible tactic of "sitting-in" at all of his classes.

The extent of our attempts were to go so far as to the writing of a contract whereby he would earn a small sum of money for each day of attendance and would forfeit an amount for each day missed.

This latter arrangement worked for a time, but soon he owed me more than he could possibly repay by staying in school for the rest of the term. He ceremoniously destroyed the contract!

We arranged for a school/work program as a counter measure, where he could earn money but, at the same time, continue his academic pursuits. While his employer at a local gas station expressed pleasure at his performance, David soon tired of the job, quit, and returned to his former endeavors, but with even more élan.

In desperation, we transferred him to a small, private school where we supposed that a more intimate environment under a liberal tutelage would work its magic. (Even though the move strained our meager finan-

cial resources, we felt it a desperation effort that we could not refuse at any cost.) After a short-lived success, he returned to his old habits, but to an intensified degree. As he approached his 16th year, he announced that he was dropping school to enter "outdoor work" in a tree-cutting firm.

Our reaction to this was not as terrible as it once might have been. After all, we reasoned, two of our girls left home early only to later pursue and complete college. This was not to be David's path, however, since he changed jobs several times but always in an outdoor setting. We encouraged him whenever and however we could. The times were traumatic, but, at least, he persisted in this field and seemed to have found his niche in working with shrubs, flowers, and trees. We are now convinced that these vigorous activities are salubrious to his condition. He finally settled down to serious work and has progressed in the workplace to a supervisory status which still demands the vigorous exertions of his former status. He has taken his equivalency certificate for high school and has contemplated attending a local college at night school.

Eventually he married and fathered our two lovely grand daughters. While his medical condition remains, of course, his adjustment through the responsibility of marriage and fatherhood have encouraged him and us immeasurably. He continues, however, to run into the effects of diabetes as he wrestles with obtaining medical coverage under insurance plans that either flatly deny coverage or make insurance such an exorbitant purchase that it is virtually inaccessible. These woes continue even though he has not had a "medical event" for many years. To a lesser degree, the condition interposed itself in his obtaining a drivers' license — an absolute necessity to his working. Although, with

persistence and perseverance, that impediment was surmounted.

The incidents recounted here are personal and abbreviated, but they have evolved over many years. Many details and incidents have, of necessity, been omitted in the search for brevity. They should show, however, as they have shown me, that both David's and our family's record of turmoil could have been alleviated to some extent by our reaching out for the abundant and quality help that is available and that we now recognize. It should also document that the family must work in tandem with the physician and the school and, certainly, with the workplace when that is in order. (The process is, of course, reciprocal. While we were perhaps delinquent in "checking up" with school authorities on David's progress, they were tardy in flagging his disruption of his class routine and, I suspect, sometimes "just as happy" to let him wander off to the nurses' station where the problem was then someone else's concern.)

I hope, also, that it will be of value to the counselor who deals with these types of conditions, to understand the psychological impact on families as well as on the person so affected. I am convinced that the "hidden disabilities" add a great psychological burden to those affected but are more easily overlooked by even professional people who are confronted by a person who gives every appearance of "normality."

Finally, and personally, I hope that it will constitute yet one more link in the understanding between a father and his son, that love is accessible no matter the impediment and that growth is contingent on mutual respect, understanding, and a determination to seek solutions wherever they might abide.

Mr. Bourgea is editor, *American Rehabilitation*. [Note: David welcomed his father's initiation of this article and provided helpful comments on its content. Richard Melia, Contributing editor.]

Job Matching In Massachusetts PWI

The Massachusetts Project with Industry, Inc. (MPWI) is a public, non-profit corporation that conducts a job matching service for job ready people with disabilities.

Although the agency is housed in space provided by the Massachusetts Rehabilitation Commission, its work is not restricted to MRC clients. Any qualified person with a work-related disability may use the service.

According to Executive Director Martin Kennedy, the MPWI process works as follows: Member companies ask MPWI to help recruit disabled people for specific openings. When a company calls in a job order, MPWI scans its files, selects appropriate can-

didates and then sends applicant profiles to the company.

MPWI works with the employer to schedule interviews and conducts a followup on the interview to give feedback to the counselor or client about the interview process.

Disabled people with a specific career objective—and the qualifications to match—benefit the most from this service, Kennedy reports. Typical job openings are for electro-mechanical assemblers, secretaries, word processing, and degreed programmers.

For further information, call (617) 542-1799, voice and TTY.

—*Together*, Info Center for Individuals with Disabilities, Boston.

Work-Ability: A State Transition Program

Gail Zittel

Work-Ability is a dynamic program in California with a clear purpose and specialized services requiring the linking of several agencies and community groups with public schools. It has the requisite information needed to qualify as a replicable program for state-wide dissemination: Comprehensive description of program components, an evaluation of positive impact on students, and analysis of costs.

As the director and as the Vocational Education Division's Special Needs consultant, I have witnessed the maturation of the Work-Ability concept that involves the placement of disabled youth between 16 and 21 years of age in private sector jobs. The concept evolved from one project to a mushrooming system of varying services for youth, spread across the state. It is best described in a letter from a project director to an inquirer from another state:

Dear Ms. Wetzel:

I will attempt to reply to your request of January 14th but, I must warn you, development of our programs has been long and sometimes a tedious task.

Our venture into this area of transitional programs began 3 years ago. At that time and as a resource specialist in one of our high schools, I became to-

tally disgusted with the lack of preparation of students offered by our district. I launched a one person campaign to change conditions by obtaining state and federal grants in these areas. The first was a state grant for Work-Ability, now funded for our 3rd year. Basically, Work-Ability has as its features:

1. A state level cooperative agreement between the State Department of Education, the Department of Rehabilitation, and the Employment Development Department.

2. A local agreement specifying each agency's responsibilities.

3. A school board's adoption of a program for transition presented by myself.

4. Stipend for 11th and 12th graders to begin work while still in school.

5. A placement program concentrating upon local business and industry.

6. State level meetings four times each year to assist each other over problem areas.

7. A very active person in the State Department of Education.

This project has led to Job Training Partnership Act, PL97-300. We have captured contracts exceeding \$900,000 to date under JTPA. Our JTPA programs range from serving preschool children to older workers 55

years and older. Most have been designated innovative in nature and all are specifically for either handicapped or economically disadvantaged. We have become the prime service provider for our SDA.

All of this has meant long hours (6:30 a.m. 'till 6:30 or 7:00 p.m.) months on end. Even so, my task was made easier by having 16 years of industry experience (Rockwell International) in the field of proposal development and negotiations.

We currently are developing a partnership arrangement with Rockwell for development of science and math curriculum for 4th-6th graders which we hope will lead to major revision to our secondary schools programs in this area. This program is currently receiving a lot of attention in the state and federal political arenas. This will result in a proposal for approximately \$1.25 million for a 25-month program. The National Science Foundation and the Federal Department of Education are involved with possibly the Department of Health and Welfare and the National Aeronautics and Space Administration.

Without knowing specifically your schools' goals, it is difficult to offer specific advice. My suggestion is that you do the following:

1. Develop a multi-year plan on



(Top, left and right) Jeff, an employee as a busboy for 3 years in an exclusive restaurant, and his mentor, Barbara, go over the place setting, an important aspect of the ambiance for diners. Jeff and Barbara have formed a good relationship as they share both duties and friendship. (Middle, left) A food service class in a Regional Occupation Center presents basic skills that will be applied later in a Work-Ability job. (Middle, right) A Work-Ability clerical worker goes over an incoming inquiry with her supervisor in a San Francisco insurance firm (At right) A postal trainee gets some pointers from his teacher/employer in a mail processing area.



where you want your district to go.

2. Develop a concept proposal on how you would get there.

3. Look for funding sources that will fund *parts* of your program.

4. Follow the *Federal Register* and your state's grant centers on availability of grants.

5. Write a lot of applications and don't despair if you do not receive one. Grant writing takes a lot of practice but even more perseverance and determination. The important thing is to keep your goals in mind and refine them as you go along.

6. After each rejection for grant, continue to pursue it as to why you didn't receive it. This is a learning process and try to learn from each attempt to make the next one better.

7. Be responsive to the application but think of the readers and evaluators. Make it simple and understandable and easy to read.

8. Attend as many conferences as possible in the areas of your goals; you need to meet and test your ideas with others. Don't copy what they are doing but use those data to become innovative and different in what you wish to accomplish.

Sincerely,

Milt Wilson, Coordinator
Vocational Education

Every local project in Work-Ability is different. Rural, urban/intercity, and suburban applications vary according to the personalities of the project leaders, the types of students being served, employment opportunities, and the needs of the local school board. The same placement criteria, however, apply to all of the current 60 projects, which include 284 schools and over 3,000 students. Vocational education, special education, and regular education personnel must either help students obtain permanent or

part-time jobs after the students leave high school or ensure that they pursue continued education or an advanced degree. A sheltered workshop or activity center is not considered a placement.

Work-Ability requires a state fiscal interagency process to succeed. In 1981, three California state agencies assumed primary responsibility for the problem of unemployment or underemployment. A state leadership effort combined the financial resources of California's rehabilitation, special and vocational education, and employment agencies by offering grants to local schools to pay for student sti-

pends, job placement, and job follow-up services. Although the Department of Education is the sole agency responsible for evaluation and training, all three agencies have designated project leaders. Any agency that experiences difficulties coordinating services with another can contact the respective state project leader, who then clarifies communication with the respective local directors. Most of the 34 original Work-Ability organizations aligned rehabilitation counselors, employment specialists, and vocational and special education personnel with private industry councils and private employers.

Work Ability Cost and Employment Benefits

Preliminary Findings for the First Year Program (1982-83)

Work Ability is a successful in-school program for high school age handicapped youth. It links the resources and specialized services of the California State Department of Education (SDE), the Employment Development Department (EDD), and the Department of Rehabilitation (DR) with local educational agencies (LEAs) to provide a comprehensive vocational and employment preparation programs.

Program Cost

Total: \$2,822,000 for 1,903 students

Per-student cost: \$608 for state agencies, \$809 for LEAs

Employment Outcomes (EDD quarterly reports for 1,024 out-of-school work Ability youth)

Total wages: \$3,841,049 for 5 quarters —

Quarterly employment rates increased 16 percent (55 to 71)

Quarterly wages increased 64 percent (\$603,901 to \$988,211)

Program Employment Benefits (Portion of Work Ability employment outcomes greater than comparison group sample)

Total wages: \$834,465

Employment rate: From 6 to 12 percent higher quarterly

Finding:

One year after leaving school the Work Ability youth had increased earnings that exceeded the state cost of \$622,592 (\$608 per student times 1,024 students).

One project director in Contra Costa County described one of her students, a graduate in June 1985. People would say to her, "If you can place him, you can place anybody." He has minimal verbal skills, but with the schools' and parent's supporting the goals for her son, she reports he is successful and working as a stock clerk in a store. He has been mobility trained by the school, closed as a "26" Department of Rehabilitation, and isn't in a sheltered workshop or sitting at home.

Another student in Merced is a senior who is enrolled in a meat cutting class and couldn't read labels on meat packages when he began as a junior. Through the instructor's assistance, he learned to read labels of the meat cutting trade, the connecting words that made words sentences, and found a reason to read, because he had the promise of a job. In March, he checked out his first library book on meat cutting, and in June he graduates with a full-time job at a local meat processing plant. He taught his teachers that learning words must relate to the "real" world, and establishing ways to overcome severe learning handicaps.

Recognizing that no model will endure unless the autonomy of the local communities and school boards is preserved, the state leadership awards both the clout and the credit to the local teachers, parents, school boards, agency representatives, and legislators for all program successes. But, although local projects retain a real sense of autonomy, the state leadership does require all project directors to attend four planning meetings (paid through grants) to assist one another with local problems. A steering committee of 15 project directors establishes agendas, locates speakers or resources, and conducts workshops featuring difficult problems affecting

success rates. Topics may include how to work with the Supplemental Security Income student, designing public relations and marketing programs, conducting community and school board presentations, or forming a job club.

Work-Ability has been a surprisingly attractive proposal for schools, a partial solution to poor attendance, dropout problems and the absence of teacher and pupil satisfaction. Over half the 1,200 students served in the first year were 4.5 grade levels behind in math, reading, and English.

Work-Ability has only three entrance requirements for a student and disability is not one of them. First, the parents or guardians must be willing to accept the separation of the child from the welfare system. Second, the student must attend school regularly and be willing to learn the social and emotional skills needed to succeed at work. Finally, the professionals involved from the three agencies must be cooperative. If students are supported and supportive, schools that want to succeed will succeed.

Because of its successes, the California Legislature is in the process of funding expansion of the program in

1985-1986 by approximately \$3.5 million in state funds. This appropriation will be available because of a research project on the employment outcomes of students who participated in the first year of program implementation, 1982-1983.

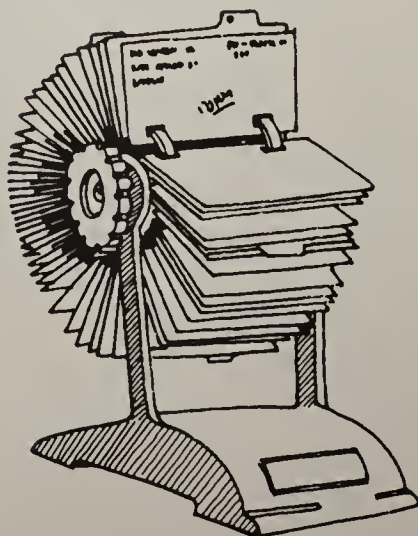
Cost And Employment Benefits

The Work-Ability cost and employment benefits are reported by the California Department of Education (see box inset).

In 1985-1986, a funding source will add at least 25 new projects to the system through the use of federal rehabilitation act funds and the local schools' state or general funds. Called Work-Ability II, this project will provide job placement services to adults in vocational schools and classes called regional centers and programs; it will operate with financing from the Department of Rehabilitation and build on the existing Work-Ability projects, ensuring vocational services for youth and adults who are rehabilitation clients.

Work-Ability has broadened job training and placement services with the use of existing funding, funding that previously would not have been shared among the agencies. Not all programs or students succeed but, as we improve our knowledge, more handicapped youth will be leaving our high schools with genuine promises of a job or an advanced degree. As one teacher declares: "Before Work-Ability, my students left school and fell off a cliff while their nonhandicapped peers crossed plateaus or climbed mountains. Now we're making mountain climbers in Trinity County."

Ms. Zittel is director of Project Work-Ability and a special needs consultant to the California State Department of Education's Vocational Education Division.



Vocational Rehabilitation: Perspective On Transition

Patricia G. Kallsen and Susan B. Kidder

The OSERS concept papers on transition and on supported employment that were published in the spring of 1984 re-emphasized the relationship between vocational rehabilitation and special education. Transition from school to work is not a new concept to rehabilitation professionals nor to special educators. Many states, including Wisconsin, had work experience programs for students with exceptional needs as early as 1965 that were cooperatively funded and managed by vocational rehabilitation and special education. Many of these programs continue to function in the 1980's.

Given the existence of transition programs in a variety of settings around the country, why did the OSERS papers cause such excitement in rehabilitation and special education agencies?

Issues

The concept papers raised a number of issues regarding education, rehabilitation, and work. They include the relationship between special education and vocational rehabilitation at the federal, state, and local level; the relationship between transition and supported employment; the system changes that must occur to accommodate new agencies and individuals in

the process of transition, *e.g.*, the concept of "parents as partners;" wrap-around services from the adult support system, etc.; and training qualified personnel.

Relationship Between Special Education and Vocational Rehabilitation

Vocational rehabilitation administrators, professionals, and advocates strongly supported the creation of the Department of Education, the creation of the Office of Special Education and Rehabilitation Services (OSERS), and the move of the Rehabilitation Services Administration from the Department of Health and Human Services to the education agency. There are many similarities between education and rehabilitation, *e.g.*, the mandatory, individualized planning process. The similarities themselves can be confusing and must be addressed during the development of cooperative agreements between special education and vocational rehabilitation. For example, both agencies can sponsor work experience programs although the procedures used and the staff qualifications may be somewhat different, both agencies can purchase equipment for the use of the person with the disability, and both agencies can conduct vocational assessments to assist in de-

veloping individualized goals and a program of training. Where both agencies have responsibility, there is the danger that neither will assume it or there may be unnecessary duplication.

There are many dissimilarities, however, which make the implementation of transition much more challenging than the concept would suggest.

Organizational Structure

Among the dissimilarities is the organizational structure of rehabilitation and special education. At the federal level, Rehabilitation Services Administration (RSA), includes a central administration and 10 regional offices. RSA is a policy-making body for all vocational rehabilitation agencies which explains the many similarities from state-to-state. The regional offices provide program review functions, determinations on policy questions submitted by the state agencies, and consultation to state agencies on program implementation and evaluation.

State vocational rehabilitation agencies provide the services to clients and operate under a variety of organizational, fiscal, and legislative mandates imposed by the states.

The vocational rehabilitation pro-

gram is conceived as a partnership between the federal and state agencies with neither one having total control over the scope and nature of the agency. Vocational rehabilitation services are typically provided by rehabilitation counselors in field offices that are located in communities around the state. Within the state vocational rehabilitation agencies, there is a direct relationship from the administrator through the supervisors to the rehabilitation counselors and, ultimately, to the clients. Statewide uniformity of program and policy can be established in the vocational rehabilitation agency.

At the federal level, the Office of Special Education is a centralized policy-making and compliance review agency. State directors of special education typically report to the Secretary-Director-Administrator of the State's Education agency, who may be elected or who may be appointed by a State Board of Education. The concept of home-rule or local control is more evident in special education. The degree of control exercised over local special education programs varies considerably from state-to-state. Both federal and state law establish minimum standards for the nature, scope, and operation of special education. Within these constraints, Wisconsin has a strong tradition of local control. The special education program can vary significantly among school districts, depending upon the philosophy of the school board and the fiscal resources available. The state special education agency influences education programs at the community level through compliance reviews, policy setting, and funding reimbursement.

Function

A second dissimilarity between vocational rehabilitation and special ed-

ucation is the concept of compliance versus goal setting and program evaluation. State special education agencies have a responsibility for compliance monitoring, *i.e.*, assuring that local special education programs follow the policies and procedures established by PL 94-142, the Education of All Handicapped Act, and state laws and regulations pertaining to special education. Special education does not typically establish goals for numbers of students participating in vocational programs, numbers of students referred for transition planning to providers of services to adults, etc. While there are assurances regarding the education program that must be provided, special education does not establish outcome goals against which the success of the program can be measured.

In contrast, state vocational rehabilitation agencies are noted for their efforts in program evaluation, program monitoring, and program accountability. (These efforts have sometimes been met with sharp criticism by advocates who accuse vocational rehabilitation programs of being overzealous in counting "26's", *i.e.*, people who are successfully rehabilitated.

RSA has sponsored projects to develop and recommend national program evaluation standards and quality assurance processes and procedures. The Council of State Administrators of Vocational Rehabilitation (CSAVR) provided strong support to RSA, the Dept. of Education, and, finally, to Congress to include an extensive information gathering and reporting function in the rehabilitation regulations in 1984. Rehabilitation agencies establish both qualitative and quantitative goals for their state programs. In Wisconsin, these goals are incorporated with fiscal responsibilities in an annual performance contract

that is negotiated between each of our 21 field offices and the central office.

Eligibility For Service

A third difference between special education and vocational rehabilitation is that of eligibility for services. Not all special education students are eligible for services from vocational rehabilitation. The VR eligibility criteria include the presence of a physical or mental disability that is a handicap to employment *and* the reasonable expectation that the provision of rehabilitation services will result in benefit to the person in terms of employability (sometimes referred to as the feasibility criterion). There are students in special education who do not have a handicap to employment. There are also students in special education who are severely and/or multiply disabled and who are not feasible for traditional employment options available in a community.

There are also students with disabilities in the public schools who do not require special education programs. Many have physical or medical conditions that are slowly progressive or which represent a handicap to employment. These students would very likely be eligible for vocational rehabilitation services. More must be done to address the unique needs of these students for transition. Their needs were not specifically identified in the OSERS paper; nor has there been recognition of this group as clients of vocational rehabilitation or independent living centers.

The transition concept should be expanded and clarified to include these students with disabilities who are not in special education but who may be eligible for vocational rehabilitation and in need of transition planning. One of their acute needs is training in independent living skills so that they can successfully transition from the

structured setting of the school and home to living in the community where they work or attend post-secondary training programs. When we develop and implement transition programs at the field office and public high school level, we must be very certain that we recognize both the differences and the similarities in the population served by our local agencies.

Terminology

The fourth and final dissimilarity is related to the definition of the popula-

tion and has to do with the acronyms and terms used by special education and vocational rehabilitation. The change in terminology and focus from special education to rehabilitation suggested by "student" versus "client" is only one example. In Wisconsin, we in vocational rehabilitation are developing and attaching glossaries and definitions of acronyms to documents, such as our *Mid-Range Plan for the Eighties*, which are widely shared among agencies. Developing a common understanding of vocabulary

is also one of our primary objectives as we work with the Wisconsin Department of Public Instruction to revise our existing cooperative agreement.

The implications of the dissimilarities between the two agencies in regard to transition are that transition programs will probably take longer to develop than the concept paper and transition projects suggest; that programs will demonstrate considerable variation between communities and states; and that there will not be a uniform policy or manual of expectations which can be shared with parents, clients/students, or other agencies involved in the process.

Relationship Between Transition And Supported Employment

The simultaneous release of both OSERS papers on transition and on supported employment created the impression that transition was designed specifically for the population described in the supported employment paper. In Wisconsin, we have spent time discussing and clarifying the concepts with vocational rehabilitation staff and with other agencies that are or might be involved in one or both programs.

Supported employment represents a new social policy towards people with severe disabilities. This emerging social policy expresses a sense of the rights of people with severe disabilities to work experiences, normal social relationships, and the *right to have choices* which provide them with an opportunity to contribute in the workplace. Within the rehabilitation community, this emerging policy challenges our traditional definitions of work and the role of vocational rehabilitation in the transition of students with severe and/or multiple disabilities from school-to-work.

Supported employment requires

Vorse Sense

Transition from school to work for severely handicapped youth need not be a dry, humorless subject.

In 1983-1984, the National Institute of Handicapped Research contracted with Harold Russell Associates to identify, visit, and describe nine exemplary transition models. One of the sites was Project VORSE (*V*ocational *O*ccupational *R*ehabilitation in *S*pecial *E*ducation) in Utica, New York. A Youth Service Unit in the Utica Area Office of Vocational Rehabilitation (OVR) serves as the focal point for local cooperative efforts relating to occupational preparation of handicapped youth.

Project VORSE has been very successful. In part, this is due to the outstanding individual attention provided youth by outstationed vocational rehabilitation counselors who help integrate special education, vocational education, and vocational rehabilitation services for special education students. But no doubt, this success can also be attributed to the fine sense of humor of the staff who wrote the following explanation of their project:

MEMO

The VORSE project, due to its expansion into a new area of vocational rehabilitation, has found it necessary to develop certain new concepts. This process, inherent in program development, is covered in this memo to edify those individuals unfamiliar with the new esoteric terminology.

The first area to be illuminated is the pronunciation of VORSE; it rhymes with horse. This, of vorse, makes pronunciation easier in conversation in meetings when we are having verbal intervorse. We are not trying to vorse the issue here, but we vorsiferously back this pronunciation.

The next topic is the envorsement of certain OVR programmatic mandates. We believe that a "case closure" by Unit 3 should be considered divorsed, and if a status change is disallowed, it is revorsed. Paper work naturally is deemed VORSE manure which is reviewed by our supervorsor.

If these changes are unacceptable, we will view this philosophically, since you can lead a VORSE to water but you can't make it drink. Fitting this motif, our interns will be hencevorse called volts and villys.

This is probably the vorse thing we have ever written, but once in motion, it was irrevorseable.

May the VORSE be with you.



that vocational rehabilitation at the federal and state level address issues such as feasibility for vocational rehabilitation services, the definition of time-limited/short term training, the criteria for successful closure, and the impact upon more traditional populations of clients served by rehabilitation.

Supported employment, however, will be an outcome of the transition from school-to-work *only for a small percentage of the special education students*. The majority of students in special education have opportunities and are expected to work for wages on jobs in the community without ongoing employment support immediately following completion of the secondary program or following post-secondary training. For those who would typically enter work or day activity programs following completion of the secondary program, however, supported employment offers a choice and a new opportunity to participate in the community alongside non-disabled peers. Supported employment is an important option as schools and adult service providers plan for the transition of students with multiple and/or severe disabilities.

Vocational rehabilitation and spe-

cial education, however, must not allow concerns over supported employment to distract them from collaborative planning for transition programs for students who are not in need of supported employment.

System Changes To Support Transition

One of the key issues in transition is whether it is possible for us to afford, design, and maintain employment opportunities for people with disabilities in conventional, typical community workplaces.

Fiscal And Programmatic Responsibilities

On the issue of funding, the answer in Wisconsin (and in many other states) is a qualified, "Yes." There is national support for transition programs and vocational education for people with disabilities reflected in the Carl E. Perkins Act for Vocational Education (1984). The Developmental Disabilities Act emphasizes community-based vocational programs (1984). There is renewed emphasis in special education and vocational rehabilitation on both transition and supported employment through project funds. Wisconsin and other states have state support in the form of legislation, funding, and policy to develop local projects that demonstrate transition from school-to-work. Local provider agencies, including rehabilitation facilities and independent living centers, have demonstrated a willingness to become involved in pilot projects and program innovations when schools have invited them to assist in transition planning and curriculum development.

There are questions yet to be answered regarding the fiscal resources required to accomplish successful transition programs on a large scale and which agency assumes responsi-

bility for specific services. We are fortunate in Wisconsin to have a nationally recognized model of curriculum development and in-school vocational programming for people with severe developmental disabilities. The cooperative efforts of the State Division for Handicapped Children, the Madison Metropolitan School District, and Professor Lou Brown of the University of Wisconsin have given us a demonstration of what can be accomplished by people with severe disabilities if they have access to a well-developed transition program. The Madison model starts vocational programming as early as age 11 for people with severe developmental disabilities.

The costs to develop and maintain this program are high, but the long-term benefits to the person and to taxpayers are potentially dramatic. Nearly 100 percent of the graduates of this program are employed at, or shortly following, completion of secondary school which reduces the long-term support costs in the adult service system.

In Wisconsin, we are pleased to have a combination of state and federal funds in Vocational Rehabilitation, Vocational Education, and Special Education to demonstrate and evaluate projects in transition, which in some cases will also "pilot test" the concept of supported employment. The programs are varied. One model uses designated vocational instructors, *i.e.*, special education teachers who have training in vocational assessment and vocational education and who provide support to special education students enrolled in vocational education. One project will establish a support system in the local vocational and technical school to assist students with learning disabilities to successfully complete post-secondary training and degree programs and become employed. Several

programs will test the use of work experience for students with severe disabilities in achieving successful employment after graduation in both rural and urban settings.

Through these and similar projects, we hope to accurately predict costs of transition programs and the impact on education, rehabilitation, and social service agencies. These programs should also demonstrate the barriers to developing transition programs, some of which are expected to be funding issues and eligibility requirements for fiscal resources.

Transition programs, particularly for people with severe disabilities, raise questions regarding the roles, responsibilities, and authority of education, rehabilitation, manpower, and social service agencies. Our success in developing public policies, practices, fiscal and staff resources will depend to a great degree on how well we in vocational rehabilitation can enhance working relationships with special and vocational education, consumers and parents, employers, and local providers of services to children and adults with disabilities.

Employers, Parents As Partners

Parents of students with disabilities have repeatedly expressed the desire for vocational rehabilitation to include them in planning with, and for, the transition of their children from school-to-work. Vocational rehabilitation agencies generally work directly with the person with the disability, particularly where that person is over 18 (or over 21) and considered to be an adult. Frequently, parents who have been involved in the education program for their child feel shut-out of the planning for their child's rehabilitation program. While vocational rehabilitation must respect the client's right to confidentiality, there are many ways to help the parents learn

techniques for appropriate and effective involvement in the transition process.

Advisory committees which include parents, consumers with disabilities, and employers may provide a forum for discussing strategies and making recommendations regarding vocational and transition programs within secondary schools. Many parents of people with disabilities have extensive experience in working with local schools and state special education agencies. Some have experience on their local school boards and state-wide education-related task forces. This experience would be invaluable to rehabilitation staff at the state and local level as we attempt to influence and improve school curriculum and transition programs for young people to move from school-to-work.

In Wisconsin, we have been conducting research in the use of functional assessment in determining eligibility and developing rehabilitation plans with clients. One of the side effects of this has been the recognition that functional assessment becomes increasingly important with people who have developmental disabilities, brain injuries, or are non-verbal. Parents and family are an important source of information on likes and dislikes, abilities and limitations, and disincentives related to employment and independent living.

We are finding that parents of people with severe disabilities are a unique resource in the training of their children. They are a source of training in the concepts of money and in developing self-care and independent living skills. They are also able to assist in the development of their child's physical stamina. We found a number of work experience programs suffered because the child/young adult with the severe disability did not have the stamina to work or attend school for 6-8 hours a

day.

Parent of children with disabilities are business people, managers, blue-collar workers, supervisors, and secretaries. Some may be employers and willing to give a young adult with a disability a chance at a job or training site. Parents who are employers may be willing to ask other employers to provide training or employment. Parents who are not themselves in a position to hire usually have friends, relatives, and acquaintances who are. Various personnel studies have indicated that the majority of jobs are found through the help of friends and family, not through the efforts of placement agencies and rehabilitation programs. Parents and family may be a major factor in accessing the informal employment network in many communities.

The role of employers in transition programs cannot be over-emphasized. The Madison Metropolitan School program for students with severe disabilities has developed over 100 job settings which enable students to learn marketable skills, explore likes and dislikes, and develop desirable work habits with the help of teachers, job coaches, volunteers, employers, and coworkers.

The employers involved in the Madison program and in other programs around the state are the best salespeople we have. They recruit new employers to participate in transition programs, willingly allow "tours" of their workplace, participate in panel presentations at conferences, and participate in developing training materials for education and rehabilitation staff. They appreciate the well-trained employees they hire as a result of the transition programs that include regular supervision and on-the-job consultation from teachers, job coaches, and rehabilitation counselors.

Technology

Vocational rehabilitation must adopt and adapt technology which has been developed to support successful job matching, job modification, and job placement. The use of automated diagnostic interviews that join with assessments of functional abilities and job descriptions can accomplish in minutes what now requires hours of a rehabilitation counselor's time. Automated systems such as Abledata and the Job Accommodation Network (JAN) [See Mr. Rochlin's paper, this issue. Ed.] can provide information in seconds regarding job modifications and equipment available to help a person with a specific problem to successfully perform a job.

The technology is available to search thousands of job descriptions on behalf of a client in order to develop a transition and rehabilitation program which successfully matches the person with a disability to a job that he/she can attain and retain. The same job descriptions may be used to provide the student and teachers information regarding the minimal skill levels which must be attained to perform certain jobs. In this way, the reality of the job can be translated into specific curriculum for the student. In our local vocational rehabilitation field offices, the technology accommodates the development of local data banks of job-ready clients/students so that employers who call with job openings know that vocational rehabilitation counselors will prescreen and refer only those interviewees who can perform the job.

Training Personnel

We have generally low turnover among our state vocational rehabilitation staff. In one of the field offices in Wisconsin, the "youngest" counselor has 12 years of experience. Line supervisors and mid-level management staff are generally promoted from the

ranks of the counselors. While this presents a wealth of experience, it also represents a significant challenge as we attempt to change attitudes, policies, and practices in relation to transition.

Most of the effective techniques in functional assessment, job analysis, job matching, job training, job follow-up, and the use of technology, particularly for students with severe disabilities, have been developed fairly recently. Some of these techniques have come not from vocational rehabilitation, but from special education. One of the issues facing rehabilitation is the development of training programs to educate new vocational rehabilitation professionals in these new technologies.

A more pressing issue, however, is to develop in-service training programs for rehabilitation and special education personnel who will be working with transition programs. This training must provide knowledge across the disciplines and should address the specific skills which are needed to work with students and parents who expect opportunities and choices for employment. It must also address the skills and knowledges required to produce system changes. [See Melia excerpt, box, this issue. Ed.]

We need to work with education, manpower, social service agencies, parents, and consumers in order to develop training programs for the general public who will meet our students in transition, public administrators, and elected officials who determine policy and funding, and others in the community who are responsible for maintaining and supporting transition programs. Our efforts at transition can be frustrated in many ways. An example is the judge who refused to support a parental lawsuit regarding an appropriate education for their son

who was unable to read because of a learning disability. The judge said that an individual with an IQ of 130 couldn't possibly have a learning disability.

Summary

Vocational rehabilitation has the knowledge, expertise, and organization to influence change in the system, even among agencies which are much larger and receive greater funding. In Wisconsin, we have chosen to fund small demonstration projects in local communities as requested and developed by our vocational rehabilitation field offices. The majority of these projects address transition programs for people with a variety of disabling conditions. We discovered that a small amount of funding from our agency can raise significant staff and fiscal resources from special education and social service agencies at the community level to develop community options on behalf of transition.

The concept paper on transition can represent an exciting challenge to both vocational rehabilitation and special education in the coming years, as the vision of the mid-1980's becomes the reality of the 1990's.

Ms. Kallsen is Administrator, Division of Vocational Rehabilitation for the Wisconsin Department of Health and Social Services. Although Ms. Kallsen is a native of Minnesota, she and her family (husband, Jim, and two sons) have adopted Wisconsin as their home.

Ms. Kidder is the Section Chief for Planning and Program Support, Wisconsin Division of Vocational Rehabilitation. She has a master's degree in Special Education and has 18 years of experience in counseling, supervision, and staff support in vocational rehabilitation.

Language Used or Used Language?

Ron Bourgea

Superabundance. Sue these words for nonsupport.

- "... *prior* research has indicated . . ." The verb's past tense indicates that the research has been done, so pry "prior" from the phrase and phase it to a priory (Pray. This is a prior—ity!)

- As used by most social science writers, the word "currently" has no currency; it does not buy a farthing's worth of explanation because its intent is almost always contained in the verb, as in "We are currently hiring staff." "Are hiring" has all the current that this expression needs. If, however, the author means a comparison to a past in which hiring was not being done, only then is the expression legitimate.

- "... establish a warehouse storage space" is like saying, "They are twin identical persons." A warehouse is a place in which things are stored. The word itself establishes a requisite "space" and a consequential "storage." The phrase should be given, "... establish a warehouse." Even in its second sense of a "store," the "space" and "storage" connotations are still intrinsic.

- "... a grant *has been prepared* and is now in the final stages of review." I cannot see how it could be reviewed without having been prepared. The same holds for this phrase from

the same paper: "... *has prepared* and *will have available* for distribution soon a listing . . ." How about, "Will soon distribute" with the idea that if it will be distributed, it was prepared, and, certainly, is available.

- "He is a *knowledgeable* program expert." An expert has "much training and knowledge in some special field" (*Wester's New World Dictionary*). I think that the author wanted a word like "astute" or "exceptional" or some other such qualifier.

- "The *entire* scope of magazine publishing." Scope means "the range or extent of action, inquiry, etc., or of an activity, concept, etc." (*Webster's New World Dictionary*). Since the limiting area is identified as the field of magazine publishing, "scope" surveys the range.

Elongationitisism. The simple form is preferred.

It is not often that—infrequently; are intended to—would; maintain a close working relationship with—work with; allow your son or daughter—allow your child; they run the risk of—they risk; it is designed to show—it shows; presents a discussion of—describes or discusses; and, in regard to—regarding.

Careful Writing. Simple writing does not necessarily mean clear writing.

- *Bureaucratic Bias* (Good words

that become vogue and, consequently, vague). **Broad spectrum.** Broadly speaking, spectrum has the idea of "the range," which should leave "broad" abroad. But I believe the phrase is usually used to mean "many;" so why not use that good word?

- In an article entitled, "Principles and Methods of Obscurantism" in *New Scientist*, Alexander Kohn gives us this example of beaucratic language gleaned from the 1963 Weights and Measures Act: "Every letter in any such words, apart from the initial letter of such words, shall be of such size that the smallest rectangle capable of enclosing each letter of every such word shall not be less than 9/16 of the area of the smallest rectangle capable of enclosing the largest letter, apart from initial letters, in any word of more than one letter appearing on any label on that container."

- "He *provided* the opening remarks." Strictly speaking, this sentence does not tell us that "he" made the remarks as we would assume that meaning, but "provide" is defined as "to prepare (for or against) some probable or possible situation. . .to furnish the means of support." *Webster's New World Dictionary*. "He made the opening remarks" is proper and more accurate. (He could have *provided* the opening remarks to the speaker or provided a published version to the attendees, etc.)

- A one-page announcement on a course in "Writing, editing, and proofreading for professionals" produced the following errors:

Proofreading: An "an" was written "on;" an "and" was repeated successively ("...course is unusual and and innovative"); and the parenthetical note (See, over.) was given as "(see over)."

Wrong abbreviation: ("Afternoon sessions from 1-4 pm.") Afternoon is

given correctly as P.M., p.m., or PM. "pm." is an abbreviation for "phase modulation" or "premium."

Faulty logic: In the paragraph that lists the course's description, we are told of "the primary aim" of the course. If that were the end, there would be no problem. But the difficulty arises later in the paragraph when secondary aims are announced under the guise of "in addition." When one uses "primary" or "first," etc., one should follow with "secondary," "tertiary," etc. and "second," "third," etc. The trouble comes from the fact that "in addition" can announce a second aim but, equally, a second term to the primary aim. The difference must be delineated.

Expressive faults: 1) The author writes that "emphasis will be placed on the development of techniques and skills for successfully proofing the writing of others." "We will emphasize proofreading skills," says in 5 words what it took 18 for the author to express. *Will be placed on the development of* is a tedious group of words that conveys little, if any, exposition. *Techniques are skills.* The author certainly doesn't aim to impart "unsuccessful" proofreading techniques. Finally when one learns proofreading skills, they automatically apply to the writing of others AND to one's own writing!

2) In another section, *Objectives*, we read, "recognize and imitate good writing styles." I would like to see a person imitate a style without having recognized it!

3) While "to proof" is recognized as a "clipped form of" to proofread, a formal announcement, such as this one is, should have used the more formal term.

Pastiche.

- Going to a conference of "invited experts" is always so dull. That is why I always choose a conference of "un-

vited" experts.

- "The authority can be found in the Rehabilitation Act of 1973 and subsequent amendments." An amendment to a law can only come subsequent to its passage, so that a subsequent amendment of this sentence that would ignore "subsequent" would finely amend the matter, subsequently.

- "The need for orthopedic services was *also* great." Nothing is wrong with "also" here except that I've noted its incorrect use in sentences like this when the precedents have not necessarily been mentioned or, if mentioned, not identified as greatly needed. If the "need reference" did not precede this "also," it should be deleted.

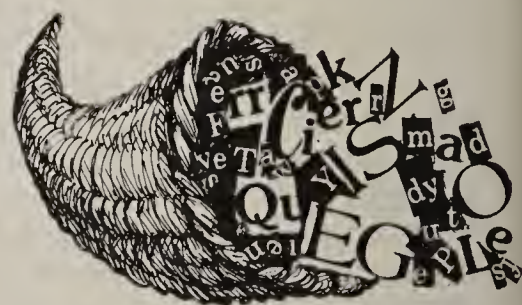
Why such thought about a precept that seems so "piddling"? After all, there is nothing grammatically wrong; nor is the fact of "need" altered. The damage is subliminal, actually, by implanting, first, the idea that there are other "great needs;" second, the wonder of what those "great needs" might be; and, third, the lessening of confidence in the author's statement.

- If ever I were to write a *Primer For Bureaucrats*, I would insert the following paragraphs as required reading. They are written by Richard Cohen, as quoted by James J. Kilpatrick in *The Writer's Art*:

"This is only me, myself, talking. In my own mind, I hear redundancies. I see them in visual observations and hear them in oral conversations. I see them in close, personal contact and feel completely surrounded by them on all sides. I guess this is because of my past experience or, as the police say, my past record. My future plans are to avoid them. (My future record has been misplaced.)

"Stories are totally fabricated and buildings completely destroyed or,

worse yet, razed to the ground. People are strangled to death in senseless murders and Washington is full of close, personal aides. They are the ones with new initiatives who get prior approval to sign off on a preplanned ongoing process with an ink pen. The president promises to personally testify, which is all right because Ronald Reagan promises a new beginning."



- "Currently few rehabilitation agencies will assume this expense." "Will assume" indicates the future. "Currently" indicates the present. One might say "now," and one might say "then," (and, of course, "now and then," if one has a mind to, but that would be another case entirely!) but the choice must be made since the two are like oil and water—they don't mix.

• ENOUGH IS ENOUGH

We beg to advise you, and wish to state,
That yours has arrived of recent date.
We have it before us, its contents noted;
Herewith enclosed are the prices quoted.
Attached you will find, as per your request,
The sample you wanted; and we would suggest,
Regarding the matter and due to the fact
That up to this moment your order we've lacked.
We hope you will not delay it unduly,
And beg to remain yours very truly.

COMMENTARY

.. On Native Americans

... In the article "Handicapping and Disabling Conditions in Native American Populations" by Jamil Toubbeh, a reference was made to the incidence of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effect (FAE) among American Indians. An incorrect source was given for these data. The correct reference should have been to the National Indian Fetal Alcohol Syndrome Prevention Program, Albuquerque, N.M., and/or to one of our publications. Over a period of almost 3 years (1980-83) our program screened all fetal alcohol syndrome suspects on 7 reservations and produced incidence figures unique in the world to date. The data came from our program.

It is unfortunate that an incorrect reference was cited. . . but we would like to refer the interested. . . reader to the proper sources of this information. . .

May, Philip A.; Karen J. Hymbaugh; Jon M. Aase; and Jonathan M. Samet. "Epidemiology of Fetal Alcohol Syndrome Among American Indians of the Southwest." *Social Biology*, Vol. 30, No. 4, 1983, pp 374-387.

May, Philip A. and Karen J. Hymbaugh. "A Pilot Project on Fetal Alcohol Syndrome Among American Indians" *Alcohol Health and Research World*, Vol. 7, No. 2, Winter 1982-83, pp 3-9.

—**Philip A. May**, Ph.D., Director, National Indian FAS Prevention Program, Albuquerque, N.M.

I wish to correct the placement of one bibliographical reference and add a reference which had been deleted

from the final draft of my article entitled, "Handicapping and Disabling Conditions in Native American Populations," which appeared in *American Rehabilitation*, Jan-Mar 1985.

Reference 19 (Sparks, S. Speech and language in fetal alcohol syndrome, *ASHA*, February 1984) should appear at the end of the statement which begins with "Learning disabilities. . ." and ends with "manifestations of FAS" (page 7-8).

The rates for FAS which appear on Page 7 of the article were derived from a secondary source which, in the final editing, was inadvertently deleted. The reference is: May, P. Personal Communication. In University of Arizona (Tucson), *Proposal to Establish the Native American Research and Training Center*, June 1983.

—**Jamil I. Toubbeh**, Ph.D., Deputy Director, Sensory Disabilities Program, Indian Health Service.

VR And Special Education Join Hands In New York State

A model for cooperative education of disabled students involving vocational rehabilitation counselors is being tested in three New York State school districts this year.

Approved for testing by the Regents this past spring, goals of the model include: increasing participation of disabled students in vocational education programs; increasing referrals to the Office of Vocational Rehabilitation for assistance with vocational planning and vocational rehabilitation services for students with disabilities; increasing student readiness either for job placement or additional training upon leaving school; and increasing awareness of parents and Committees on the Handicapped of the importance of vocational preparation while

handicapped students still are in school.

Project sites include Erie I BOCES, the Syracuse City School District, and the Putnam/Northern Westchester BOCES.

The projects use a team approach, including a special education teacher, a vocational rehabilitation counselor, and a team leader. The teams will identify appropriate methods for assessing the vocational needs of disabled students and better ways to communicate with Committees on the Handicapped. They also will develop referral systems for handicapped students who leave school.

—Reprinted from *The NYS OVR Sun*, New York Office of Vocational Rehabilitation.

Rheumatic Disease: Rehabilitation and Management. Gail Kershner Riggs, M.A., and Eric P. Gall, M.D., editors. Butterworth Publishers, 80 Montvale Avenue, Stoneham, Massachusetts 02180. 485 pages. \$34.95.

This book contains the contributions of 39 medical writers who offer their expertise on the treatment and management of rheumatic diseases. Forty-two subjects dealing with rheumatic diseases are presented under three separate sections: Section I covers "The Interdisciplinary Team Approach;" Section II offers "Techniques in the Care of Patients with Rheumatic Disease;" and Section III is concerned with "Rehabilitation Techniques for Regional Disorders and Specific Diseases." This book should be a valuable resource for all professionals who treat or counsel persons with rheumatic disease.

Refund



Oct.-Nov.-Dec. 1985

AMERICAN REHABILITATION



Review: Beyond Bureaucracy See page 4



With your eyes they could be seen in a different light.

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AMERICAN REHABILITATION

Volume 11, Number 4 The weakest ink is better than the strongest memory.

Oct-Nov-Dec 1985

4	Review: Beyond Bureaucracy	Ron Bourgea
6	VR for Psychiatrically Impaired	M.G. Eisenberg, Ph.D.
12	How to Use Electronic Communications Effectively	Jack B. Ralph
18	Computer Assisted Job Placement	Fong Chan, Ph.D. Paul S. McCollum, Ph.D. and Harry J. Parker, Ph.D.
22	Training: Voice Activated Computer	John M. Williams
26	Spinal Cord Injury Research	J. Paul Thomas, Ph.D.
31	Index 1985 Vol. II, Nos. 1-4	

DEPARTMENTS

2	Topic of State	16	Notes on the Margin
10	News, Notes, Announcements	24	Report Resources
15,30	New Publications	28	Language Used

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TOPIC OF STATE

Alcohol Misuse High In Wisconsin Disabled Population

People with disabilities in Wisconsin misuse and abuse alcohol and other drugs at a rate greater than the general population according to a survey conducted by the Bureau of Community Programs through its office of persons with physical disabilities, alcohol and other drug abuse, hearing impaired, and blind and visually impaired services.

Analysis of a broad-based survey of Wisconsin citizens with disabilities indicates that between 15 percent and 30 percent of Wisconsin residents with a disability also abuse alcohol, according to Al Buss, project coordinator with the Bureau of Community Programs, Office of Physical Disabilities.

A survey to learn more about the living conditions, lifestyles, as well as alcohol and drug use of people who have a physical or sensory disability, indicates that 16 percent of those who responded indicated they drank upwards of 11 or more drinks per occasion. Twenty percent considered themselves moderate, while 19 percent classified as light drinkers.

The survey . . . noted many people in the moderate to heavy drinking category could also be defined as having alcoholism.

The highest percentage of moderate and heavy drinkers came with people with spinal cord injury, Buss noted. Nearly one-half of the people with this disability were in the misuse, abuse, or alcoholism category.

DVR and the state's five independent living centers mailed approxi-

mately 8,000 surveys, with 3,300 returned.

Buss said that in addition to alcohol use, the study would look at prescription drug use with alcohol and use of street drugs, such as marijuana and cocaine.

—*DVR News*, Wisconsin Division of Vocational Rehabilitation.

Transition Areas Listed in Wisconsin

The following is abstrated from Wisconsin's *DVR News*. It highlights the initiatives taken by the state in its school to work program. In conducting the program, DVR cooperates with the Department of Public Instruction and other organizations.

The LaCrosse office will develop and implement a transition program for students with moderate to severe mental retardation in the LaCrosse secondary school system. The project will demonstrate use of integrated job sites in the community as an alternative to placement in a work activity program. . .

The Fond du Lac office will develop and implement a transition program for students with moderate, severe, and multiple developmental disabilities in the Fond du Lac secondary schools. The project will show that integrated community-based work sites are a feasible alternative to work activity programs with the support of community agencies. . .

The Rhinelander office will demonstrate a transition program for special education students in rural Wisconsin. The project will demonstrate that a cooperative vocational program between the schools and community agencies can result in more employment options for special education students. . .

WORKER'S COMP Project Shows 2-Year Success

As the second year of operations nears an end, the DVR/DOA (Division of Rehabilitation/Division of Administration) Worker's Compensation Project continues to demonstrate (Wisconsin) DVR's ability to serve work-injured state employees via innovative and aggressive case management. Through the first seven quarters of operation, 226 cases of work-related injury/illness were reviewed by the project counselor, 102 of these were referred into the DVR system for evaluation and services, and 56 have returned to work.

The project utilizes an intensive servicing model made possible by assigning a smaller-than-average caseload to the project counselor, Darwin Tichenor. The project also seeks to maximize the use of transferable skills and minimize training. In order to do this, the project has developed extensive resources and procedures to network throughout the state in order to find suitable alternative employment for the displaced worker. . . .

—*DVR News*, Wisconsin Division of Rehabilitation.

Services Increase Seen In Ohio

The 1986-87 biennium state budget, which has passed the Ohio Legislature and been signed by Governor Celeste, is a compromise between the House and Senate versions. For RSC (Rehabilitation Services Commission), the final version contains the good news that case services monies would increase by 15 percent. The disappointment is that no funds were included

for independent living programs and there were only continuation levels for the Personal Care Assistance (PCA) program and Community Centers for the Deaf (CCDs).

The vocational rehabilitation program had all but \$112,792 in state funds restored that had been cut from the House-proposed budget. This means that Ohio will be able to match \$50.027 million federal dollars which will potentially be available for 1986.

Funding of the CCDs and the PCA program ended up at slightly below the reduced Senate version. This was the result of all programs absorbing an across-the-board reduction necessary to balance the state budget. The independent living funds included in the House budget were deleted in the final budget.

—*News Net*, Ohio Rehabilitation Services Commission.

Wisconsin DVR Services To Expand

Conversion of the Wisconsin Workshop for the Blind (WWB) from a state-operated facility to a private non-profit business called WISCRAFT highlighted DVR's involvement in the 1985-87 State of Wisconsin Biennial Budget signed into law by Governor Tony Earl.

.....
The budget bill gives DVR the green light to establish a full complement of transition services for severely disabled individuals. This effort will work with state schools through the Department of Public Instruction (DPI) to provide work-experience training and work with state business and industry to provide job site development. A vocational transition coordinator located in central office will head this effort.

Over \$100,000 will be allocated over the next two years to provide vocational rehabilitation services to Hispanic workers who have been injured in industrial accidents. . . .

WISCRAFT is now guided and controlled by a 13-member board. The board will seek to broaden marketing efforts. WISCRAFT will continue to produce pens, door mats, fingerprint identification kits and other merchandise under contract with federal, state, and private agencies and businesses. WWB was established in 1903 and provides sheltered employment for blind and visually impaired individuals in Wisconsin.

—*DVR News*, Wisconsin Division of Vocational Rehabilitation.

Creative Arts With Older Adults. A sourcebook. Naida Weisberg, M.A., and Rosilyn Wilder, Ed.D, editors. Human Sciences Press, Inc., 72 Fifth Avenue, New York, NY 10011. Hard cover, \$29.95; paper, \$14.95.

A first in the gerontological field, this volume presents specific experiences and theories by 27 outstanding creative arts leaders and therapists working with older adults in nursing homes, community centers, and psychiatric institutions. All illustrate how the techniques of drama, music, art, dance, poetry, and prose can contribute to the vitality and social interactive abilities of alert and confused, ambulatory and nonambulatory older people.

The significance of an arts approach to the problems of growing older are noted in the book's Preface by Dr. Stanley Cath, a prominent psychiatrist. Psychiatrist Dr. George Sigel tells us why some elderly disconnect. Clinical psychologist Marilyn Barsky cites the major qualifications of an effective leader. Poet Marc Kaminsky describes the evolution of a

group in a workshop series. Each contributor meets the problems of establishing programs in various settings with ideas that work with both alert and confused elderly. In the concluding section of the book, administrators and educators who support the creative arts in their own schools and centers confirm the urgent need for this volume.

Deep Blue Funk and other stories. Portraits of teenage parents. Daniel B. Frank. The University of Chicago Press, 5801 South Ellis Avenue, Chicago, Illinois 60637. \$3.95.

Teenage pregnancy has attracted the attention of sociologists and psychologists, social workers and teachers, and, of course, parents. But in the midst of compiling statistics and arguing over alternative programs, few adults have stopped long enough to pay close attention to the young people themselves—to try to understand who they are and how they feel about their lives.

Daniel Frank has taken the time to listen. For 2 years he worked as a tutor for Family Focus, a family resource organization in Evanston, Illinois. At Our Place, the Family Focus drop-in center for black teens, he listened to the youngsters talking about their lives—their dreams and disappointments, their expectations and their fears. DEEP BLUE FUNK records what he heard, presenting honest yet sensitive portraits of adolescents confronted with adult responsibilities. Readers will be drawn into the lives of these teenagers, will share their excitement and their sorrow, and will emerge with a rare insight and new understanding.

The voices in Deep Blue Funk have long deserved to be heard. They speak out not only to concerned adults but also to other troubled teenagers. Now is the time for all of us to listen.

Review: Beyond Bureaucracy Mary Elizabeth Switzer and Rehabilitation

Ron Bourgea

By Martha Lentz Walker, with a foreword by Elliot Richardson. University Press of America, Inc., 4720 Boston Way, Lanham, MD 20706-9990. \$25.50, Library binding; \$14.25, paper text. 313 pages. Index.

Although I was privileged to have known Mary Elizabeth Switzer, the acquaintance was peripheral. In 1965, when I joined the Vocational Rehabilitation Administration (VRA) which she administered, Ms Switzer's long and distinguished career was both at its zenith and in its decline. My efforts were those of the novice scurrying about "learning the ropes" from lesser mentors whom she had appointed.

Yet her presence was ubiquitous. In the mentors (whom I alluded to) who were imbued with her philosophy. In the institutions within the agency which bore her direction and her imprimatur. In the spirit of optimism. In the constant search for a "better mouse trap." In the ebullience and the heady wine of accomplishment and in the pervasive activity of a program "on the move."

My fascination in reading Martha Walker's biography of Ms Switzer centers in ironies that arise in my own assessments of her accomplishments over the years and since her death. In

various discussions and at various times, I remember commenting on salient points of her philosophy, her ability as an administrator, and her basic humanity. These, of course, were reflections based on some first-hand knowledge, but primarily on the self-evidence of the agency and its work and on the testimony of her associates in and outside of the agency.

The ironies arise now, after having read the book, in discovering the roots in her life of those admirable facets which distinguished her as the great person that she is.

Ms. Walker's straightforward and well-documented approach to her story may chronicle the natural progression of a life devoted to people and its culmination in the satisfaction of accomplishment, but its choice of detail delineates the more important factors that molded that life and tempered her thought.

We can see, for example, the well-spring of her negotiating abilities in the lessons she learned in mediating between Henry Morgenthau, Secretary of the Treasury, and Josephine Roche, whom she had been assigned to "assist" by Morgenthau, but, also, surreptitiously, to keep Mr. Morgenthau informed of Roche's activities. She adeptly served both masters, incurred the ire of neither, and advanced

the purpose of both! And in an anecdote of Ms Roche's handling of a labor dispute in her Rocky Mountain Fuel Company, we see the lesson of arbitration which would later serve Ms. Switzer as she conducted her business in the Halls of Congress, in the political arena, and in the precincts of constituencies.

In her own account of Henry Morgenthau, she says that "he was also a person who knew how to gather around him men of ideas." The observation translated into practice as she brought to her administration men of ideals and ideas. In learning her lessons well, she not only ascribed the materials to her purpose but inscribed them with the indelible mark of her personality and the power of her intellect.

I had heard it said and personally witnessed that Mary Switzer could seize any platform to advocate for disabled people. Whether or not her remarks were prepared or delivered extemporaneously, the ducks were always in a row. The points were crystal clear. The logic impeccable and indisputable. The intent irrefutable and the desired results implacable. This tenacity of purpose was infused in her by her greatest teacher, her maternal uncle, Michael Jeremiah Moore, who counseled her to "know your facts."

And it was he, also, who coached her in speech and delivery, pointers which served her purpose all of her life and points garnered from her uncle's association with the early labor movement and such orators as its Eugene Debs.

Although it was Uncle Mike who had introduced her to what were in the early 1900s revolutionary and radical ideologies, it was at Radcliffe (where she "passed" — but never forgot — her Irish heritage amongst the Brahmin of Boston) that she honed the sociologic precepts that had formed in her earlier years under her Uncle Mike's tutelage.

An interesting note at this juncture was a skill which she learned from one of her Radcliffe professors, called a "clipping thesis," in which newspaper stories were followed, to be clipped and used as the basis for discussion and from which implications for action were to be drawn. The skill, applied years later in her neophyte struggles in the bureaucracy, were to raise the worth of her portfolio in the eyes of her first boss, Secretary of the Treasury, Andrew Mellon, and to subsequent Secretaries as well.

Related perhaps imperceptibly to that practice, I find an amusing irony in my recollection of a file room in VRA where any document or piece of correspondence might be retrieved almost as instantaneously as requested. It was a gross "computer" system before its time with perhaps fewer bytes and retrieval in vastly expanded "non-aseconds," but a useful, efficient, and workable system nonetheless! At any rate, it reflected again the notion that a precept learned and evaluated as efficient was never discarded but implemented and made serviceable.

In addition to the pragmatic counsel of her Uncle Mike, Ms. Switzer unflaggingly sought associations from which she could learn. Thus was it

from the Irish emigré that she learned of the struggle of emerging groups. And thus was it from such associations with the labor movement and with the espousal of liberal causes in college that she advocated for the common man. And, yes, thus through such leaders as Eleanor Roosevelt, Eugene Debs, Louis Brandeis, Tracy Copp, and many officials of the U.S. Government that she mined the nuggets of wisdom and applied them in her life's pursuit.

While Michael Jeremiah Moore's chief concerns for his niece were study, application, inquiry, he nevertheless had the wisdom to know that she needed cultural input to flesh out her total being. Since these concerns were beyond his ability to provide, he turned to his friend, Eugene Hough, and it was he who provided tickets to plays and operas which Mary enjoyed.

A reflection of that early acquaintance with the cultural life was her abiding interest in the arts. One of my first recollections of her was when she advocated for a small research grant related to the arts before the National Advisory Council on Vocational Rehabilitation which made final recommendation of research money to be expended by VRA. Because the money requested was modest compared to the weightier subjects and budgets scheduled for discussion, I assume that she thought it might get lost beneath the rug of heavier concerns. Of course, thanks to her good word, the project was funded without dissent and with relatively little further comment by that august body!

In perhaps a tangential consideration, but a consideration of some weight notwithstanding, Martha Walker's book explicates the sociologic consequences of minorities and sheds an understanding on their plight. It shows that dedication is a mantle not reserved solely to the Brah-

min. Additionally, it chronicles historical events that shook and shaped this nation; events in which Mary Elizabeth Switzer contributed and to which she devoted all of her energies. Many of these national and international events are mirrored against the narrower concerns of individual actors playing their roles on the governmental stage.

Ms. Walker's account will make evident the pervasive interests of Mary Switzer in mental health, independent living, facilities construction, mobility and orientation for the blind, center for deaf-blind people, and training and education of deaf people, to categorize only a few of the areas. As long ago as 1965, for example, she lobbied for school to work transition, an area still of concern and concentration two decades later! In these omniscient regards, she was guided by principles learned in seminars that she attended which were directed by Dr. Karl Menninger. In her own words, "... Whenever I would go to Topeka, I would sit in on the seminars that he [Dr. Menninger] would conduct. . . and I never came away without having achieved at least one significant insight into problems that had a very direct bearing on my own responsibilities. I remember one evening. . . listening to a discussion of the relationship of psychoanalysts to their patients and the way in which it was absolutely essential to hold an objective relationship although great human understanding of the problem was also essential. And as he drew the picture of this perfect relationship, it became for me the ideal also of the perfect administrator — the ability to stand outside the situation while at the same time to appreciate it emotionally and, believe me, after ten years of trying, this is not easy even today."

(Continued on page 14.)

Vocational Rehabilitation for the Psychiatrically Impaired: A Case Study

M.G. Eisenberg, Ph.D.

The importance of emphasizing vocational needs in the therapeutic process is predicated on two concepts: that vocational maladjustment is frequently interwoven with illness, occasionally with respect to etiology and more often in relation to recovery; and complete treatment includes recovery of social and economic status equivalent or superior, if possible, to that which the patient enjoyed before onset of illness or injury. As such, vocational issues occupy a central role in the therapeutic process. For example, Rubin and Roessler¹ have reported employment to be a major factor in reducing recidivism rates among psychiatric patients.

A variety of approaches to job counseling are available. However, one method being used with increasing frequency is based upon the application of principles derived from the operant learning techniques formulated by Skinner.^{2,3,4} This approach is commonly identified as behavior therapy or behavior modification which focuses on overt behavior.

As applied to vocational rehabilitation, the behavioral approach requires that a counselor be concerned with the sole objective criteria of finding a job for the client. Other strategies focus

on alternate objectives for their clients, such as the achievement of "job readiness" or willingness to work; the choice of a vocational specialty; or the suitability of the client for a particular job. While the behaviorist might consider these objectives as important subgoals, primary emphasis is placed on the desired behavioral objective of actual job placement. It is this focus which makes the behavioral approach an outcome-oriented, rather than a process-oriented strategy. The purpose of this paper is to present the results of an evaluation of a behaviorally-based component of the vocational assistance program available at a Veterans Administration (VA) Medical Center.

Vocational Program: Overview

In the most general sense, the vocational rehabilitation program available to patients at the VA Medical Center in Hampton, Virginia provides assistance to those patients who require assessment of work potential, job skills training, and/or job placement. Patients at this 1,100-bed full-service medical complex may be screened via testing and/or diagnostic interview. Through this initial evaluation, referrals to compensated work therapy, in-

centive therapy, educational therapy, vocational work assessment, vocational awareness and skill-building groups, or job placement may be initiated. A small monetary fund is available to assist patients with transportation costs associated with job interviews or with traveling to the job site. These funds remain available to the veteran until the first paycheck is received.

Depending upon the results of the evaluation process, patients may be referred to community or other VA-based vocational rehabilitation programs such as the VA Regional Office Vocational Rehabilitation Program, the Virginia Employment Commission (which maintains two DVOP representatives at the Medical Center), or the Virginia Department of Rehabilitative Services (which provides weekly coverage to the Medical Center). Patients must be screened by Psychology Service staff prior to referral to these latter two agencies to insure that the referee is "work ready," (*i.e.*, willing and capable of working).

Recently the job seeking skills component of the vocational rehabilitation program was evaluated to determine how effectively the ultimate goal of job placement was being met. This

behaviorally-based component to the Medical Center's vocational program has been fully functional since June 1984 and evaluation of its effectiveness was considered a necessary part of quality assurance activities.

Method

Patient Characteristics. All patients in the Job Seeking Skills Program were residents of the station's domiciliary, a 475-bed treatment environment which provides rehabilitative assistance and other therapeutic measures to ambulatory, self-care veterans. The domiciliary at VAMC-Hampton is one of 17 such treatment settings in the VA's health care network. It represents the least intensive level of care available within the spectrum of VA health services, *i.e.*, less care than that available in a hospital as measured by the required intervention of a nurse or physician but a higher level of care than that found in residential care. Generally, because of the impairment, the domiciliary patient is mildly to moderately disabled to the extent that structured daily routine and emotional support, professional intervention to carry out daily living functions, and/or professional assistance in following a rehabilitation plan are required.

Seventy-five percent ($n = 41$) of the patients investigated carried psychiatric diagnoses (in remission) ranging from major affective disorders to anxiety disorders, somatoform disorders, substance use disorders, or adjustment disorders. They ranged in age from 21 to 56 years, with a mean age of 34. All had unstable vocational histories with periods of unemployment reportedly ranging from 6 months to 4 years (mean time unemployed: 11.1 months). Moreover, when asked how many positions had been held over the preceding 4 years, respondents indicated holding anywhere from 2 to 11

positions. Length of hospitalization in the domiciliary prior to participation in the study ranged from 2 to 20 weeks, with a mean length of stay of 13.2 weeks. A majority (76 percent) were either single, separated, or divorced.

Design. Subjects were assigned to an experimental group ($n = 28$), attending the Job Seeking Skills Program, or a control group ($n = 26$), self-referred patients receiving job assistance without participation in the skills building program. Subjects were matched on the variables reported in Table 1. Outcome was assessed by comparing the placement rates of Job Seeking Skill Program participants to placement rates achieved by the matched controls.

Experimental Group Membership: Definitions. For the 5 months under consideration (June 1984 to October 1984), a total of 46 veterans were referred to the Job Seeking Skills Program. Of these, 18 dropped and were not considered in the subsequent evaluation, reducing the experimental sample size to 28. Reasons for discontinuation included irregular and infrequent attendance (*i.e.*, attendance at two or fewer sessions weekly), irregular discharge from the domiciliary due to noncompliance with rules and regulations, or exacerbation of underlying psychopathological conditions necessitating the acute psychiatric hospitalization.

Data Analysis. Simple descriptive statistics (means, percentages, range) were used to compare and contrast intergroup data and determine the efficacy of using a behaviorally based vocational treatment methodology.

Conceptual Framework and Program Description. The Job Seeking Skills Program met in 2-hour sessions 5 days a week. The first hour was devoted to learning and refining social, verbal, behavioral and writing skills;

the second was spent in searching for employment via newspaper review and phone contacts. The didactic portions of the program were predicated upon four basic concepts, including:

Personal achievement through skills training. Participants were first taught the concepts central to occupational and social skills (*i.e.*, finding job leads, arranging interviews, learning modes of presentation on interview, learning how to accept supervision and critical feedback, etc.). They were then given an opportunity to practice these skills in structured group and simulated work settings. Group sessions provided feedback to assist the participants in understanding the impact of their behavior on others and suggest modifications in their behavior to become more effective in self-presentation in real life situations.

Treatment through training in Communication skills. As group cohesion was established, training was provided to enhance effective communication. The communication component of this group program included exercises in nonverbal behaviors, listening skills, assertiveness, self-disclosure, and learning how to give and receive constructive criticism.

Treatment through training in vocational awareness. In order to make informed vocational choices, program participants were asked to identify their personal interests and abilities by assessing their past training and other experiences. In addition, they were encouraged to observe market trends, assess local hiring practices, and evaluate employment practices from an employer's point of view. Participants also learned how to present themselves for employment by completing job applications, preparing personal resumes, writing practice cover letters, role playing job interviews, and making potential employment contacts.

Mock interviews were videotaped and played back to program participants for critique and feedback.

Treatment through training in self-understanding. Program participants were taught to select personal and vocational goals from the alternatives generated. Hence, skill building exercises were presented in order to help each patient clarify personal values and establish priorities. Goal sharpening skills were presented in terms of goal-thinking (What is my goal?), trend-thinking (What past factors have helped or hindered me in reaching my goal?), condition-thinking (What present conditions will help or hinder achievement of my goal?), projective-thinking (If I don't act to change, will I still obtain my goal?), and alternative-thinking (What alternative ways exist to achieve my goal?).

The Job Seeking Skills Program represents a modification of Azrin's Job Club format.⁵ That format was selected because of the highly structured techniques used. Azrin's methodology is primarily behavioral in orientation with structure, specified interventions, and objectives clearly defined in behavioral terms. His program has been empirically derived and its efficacy evaluated statistically. This feature has been conspicuously absent from virtually all previous job seeking programs. In addition, Azrin's program evaluation is distinctive in specifying the population, following-up of all clients, grounding in an established conceptual framework (Behaviorism), and specification of procedural details. This concern for detailed specification has resulted in charts, tables, guides, reminder forms, recording forms, and standard scripts that enable the counselor to proceed on the basis of specific counseling procedures rather than vague general advice. Similarly, job seekers may use these standardized forms to

Variable	Control Group (n = 28)	Experimental Group (n = 26)
• Sex:		
Male	100%	100%
Female	0%	0%
• Mean Age	33.8	34.6
• Marital Status:		
Percent Single, Divorced or Separated	73%	78%
Percent Married and Living with Spouse	27%	22%
• Presence of Psychiatric Diagnosis	75%	73%
• Mean Length of Time Unemployed (Months)	11.3	10.8
• Mean Number of Different Positions Held Over Previous Four Years	7	9
• Mean Number of Weeks Spent in Domiciliary (Current Admission)	12.8	13.5

guide their job-seeking activities in a highly structured sequence, with the knowledge that adherence to these guidelines should result in the same degree of success obtained in the experimental studies of this method.

While the Job Seeking Skills Program instituted at the VA Medical Center in Hampton adheres closely to the Azrin format, it departs from his methodology in at least one significant way. The Job Club relies heavily upon the monitored use of telephone contacts between participant and potential employer. The telephone, rather than letters or personal visits, is used extensively as the primary method for obtaining job leads and arranging interviews. Because of the unavailability

of a bank of telephones for Job Seeking Skills Program, participants' use, a single phone was made available on a rotational basis to program members. This modification in the Azrin approach is an important factor to consider when comparing outcome data obtained from this and other comparably designed programs.⁶

Results

Of the 28 veterans included in the experimental group regularly attending the Job Seeking Skills Program, 17 (or 61 percent) located employment. This placement rate far exceeded the 12 percent (n = 4) placement rate for the comparably matched control group subjects seeking job placement

assistance directly through the State's Employment Commission specialists.

Job seekers in the experimental group started work in a mean of 24 days, whereas job seekers in the control group located employment in a mean of 47 days. Participants who obtained part-time employment of 20 hours or more per week were included in the study and considered employed. In addition, fewer interviews were required by program participants than control group subjects (a mean of 3 interviews for experimental group subjects versus 7 for control group subjects). Patients in both the control and experimental group were successful in locating comparable positions in unskilled, semi-skilled, or skilled areas depending upon their work skills. Salary was equal to or slightly higher than the minimum rate for both groups. Preliminary analysis of data indicates that the length of time required to find a job was greater for those patients who attended the experimental Job Seeking Skills Program on an irregular basis than for those whose attendance was regular.

Discussion

Data obtained in the process of evaluating the efficacy of a Job Seeking Skills Program suggest that the program's conceptual framework, behaviorism, and its specification of procedural details is effective in enabling the counselor to function with a high degree of success. While the findings reported in this paper are preliminary and a more thorough longitudinal evaluation is indicated, these initial data do indicate that persons with restricted psychosocial functioning can be vocationally placed at higher rates than previously thought possible.

Based on these initial findings and similar reports in the literature,^{7,8,9,10} many of the assumptions made re-

garding the vocational capacity of psychiatrically impaired people may warrant reinvestigation. These assumptions include the strength of the relationship that exists between future work performance and prior employment history and the relationship between a person's longitudinal psychosocial integrity and his future vocational functioning. In fact, upon re-examination, investigators may find that there is little correlation between assessments of community functioning, psychopathology, and vocational functioning.

The answer to these and other questions regarding the best methods to use in providing employment skills to the psychosocially disadvantaged person will become evident only as additional empirical research in this area proceeds. Only then will the actual capacity of these people be realized and the requisite knowledge base acquired that will permit the vocational rehabilitation counselor to most effectively maximize this population's full potential.

Dr. Eisenberg is Chief, Psychology Service, Veterans Administration, Medical Center, Hampton, Virginia.

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- 4) Skinner, B.F. (1974) *About Behaviorism*. New York: Knopf.
- 5) Azrin, N.Y., and Besalel, V.A. (1980) *Job Club Counselor's Manual: A Behavioral Approach to Vocational Counseling*. Baltimore: University Park Press.
- 6) Results of empirical studies examining job club effectiveness indicate that significantly more clients enrolled in such programs obtain employment than those in controlled samples, 62 versus 33 percent respectively. Separate analysis of data showed that using the job club format was substantially more effective in each of five cities for men, women, blacks, whites, Spanish, high school graduates, the handicapped, veterans, and the young. The jobs obtained by job club members were comparable or superior to those of control clients. The average salaries of the two groups were the same and 89 percent of the jobs in both groups were full-time. The jobs of job club clients were more likely (90 versus 79 percent) to last longer than 30 days, were less likely to be subsidized positions (16 versus 25 percent), and were more likely to have been obtained by the clients themselves rather than by the agency-provided job referrals (86 versus 71 percent).
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NEWS, NOTES, ANNOUNCEMENTS

Magazine Asks Consumer, Provider Access Questions

Sixty-seven percent of respondents to a survey on hotel/motel accessibility for travelers with physical disabilities reported that they are traveling more now than 5 years ago, according to results published in the July-August issue of *The Itinerary Magazine*.

Its editor cited greater accessibility offered by the lodging chains, transportation companies and popular attractions, as well as a better economy for the upsurge in travel by the disabled.

He reported the survey showed that 38 percent of the respondents use a hotel or motel 3 or more weeks a year, 29 percent stay 11 to 20 nights annually, and 33 percent spend up to 10 nights in a hotel or motel each year.

The *Itinerary* report reflects the second half of the magazine's exclusive two-part survey. The results of part one were published in the Jan-Feb and May-June editions and reflected the lodging companies' responses to a four-page questionnaire about the degree of access and type of services they offer, their corporate policies toward guests with disabilities, and their comments on the increased use of their facilities.

"He told our readers that they needed to know more than just this one-sided, subjective view. It is convenient to say a facility or group of facilities is accessible if you, yourself, do not have a disability and/or are trying to drum up business. So, we published a questionnaire following the January report and invited our readers to share their personal experiences and to com-

ment on the accuracy of our initial findings."

"Surprisingly, 92 percent agreed with the companies' self-evaluation."

The magazine is issued bimonthly and its subscription price is \$7 per year. *The Itinerary Magazine*, P. O. Box 1084, Bayonne, NJ 07002-1084.

Insurer Makes Best Source Referrals

Minneapolis—The Reinsurance Department of Northwestern National Life Insurance Co., which reinsures group and individual accident and health policies, has designed a program to help its clients deal more effectively with their catastrophic medical insurance claims.

The Rehabilitation Outreach Service for Employees (ROSE) program recommends specialized treatment resources for catastrophically injured or ill claimants.

"By locating the best source of care at the onset of disability, we can help the patient recuperate more quickly," said William Merriam, Vice President-Life and Health Reinsurance. "Our commitment to followup care can also reduce the incidence of future complications. These two measures are extremely cost-effective in the long run from both the patient's and the insurer's perspective."

The ROSE program is designed especially for six kinds of claims: head injuries, spinal cord injuries, severe burns, strokes, multiple fractures and premature birth or congenital birth defects. The program will eventually expand to include chronic illnesses.

Employer's Guide For Working With Learning Disabled

Agatha Christie, Albert Einstein, and Bruce Jenner—all are famous people who overcame their learning disabilities. Most learning disabled people aren't that lucky, however. They need help from others, including supervisors and coworkers.

Working with learning disabled people is the subject of a new booklet by the President's Committee on Employment of the Handicapped Entitled *Supervising Adults with Learning Disabilities*. It outlines a common-sense approach that allows employer and employee to work with personal strengths rather than weaknesses.

Disabilities range from dyslexia (difficulty in learning to read) to dyscalculia (inability to do math) and fall into five categories. Its author suggests techniques for proper job placement and accommodation in each category.

Single copies of the booklet are available from the committee at 1111 20th Street N.W., Washington, DC 20036.

Baltimore Hotel Accents Access

On July 1, Baltimore, Maryland hosted the opening of a prestigious new property, the Sheraton Inner Harbor Hotel. Located less than 5 minutes from the city's bustling Inner Harbor, convention center, and business and financial centers, it has 16 oversized rooms especially designed for handicapped people.

According to its general manager, "We have worked very diligently with our architects to ensure access, comfort, and safety to all of our handi-

capped visitors." Each of the rooms is larger than the standard hotel bedroom. In addition, the bathrooms are oversized and include traditional handicapped amenities, such as specially designed lavatories.

The City of Baltimore itself is engaged in an extensive program to provide handicapped access to all areas of the city, most particularly those to which visitors and conventioners would be directed. All curbs are ramped and all major attractions boast easy access. For more information on the Sheraton Inner Harbor Hotel, call (301) 962-3600. For a brochure on accessible attractions in and around the Baltimore area, call the Baltimore Office of Promotion and Tourism at (301) 752-8632.

Videotapes Promote Independent Living

Applied Video Services (P.O. Box 7630, Berkeley, CA 94707) announces the availability of two videotapes on independent living, *Attendant Care Basics* and *Getting On With Living*.

In the first, six people with disabilities who have a variety of attendant needs, discuss and demonstrate attendant activities and techniques. There are sections on housecare, bed mobility, skin care and bathing, range of motion and exercise, dressing and grooming, transfer and body mechanics, bowel and bladder programs, wheelchair maintenance and transportation, and the employment contract.

In the second film, the cast of *Attendant Care Basics* have the opportunity to tell the stories of their lives. They range from a young man in his early 20s who was recently disabled in an industrial accident to an elderly gentleman who has lived an exceed-

ingly varied and productive life with multiple sclerosis. They are excellent role models.

Both tapes are available in 3/4" U-matic, VHS, and Beta formats. The purchase price is \$400 each or \$500 for the set. The first film runs 52 minutes and the second 57.

NTID Produces Deafness Resource

An increase in deaf awareness by the general public has sparked the most comprehensive resource bibliography on deafness ever compiled.

A Deafness Collection: Selected and Annotated is a quick and easy reference on a variety of related disciplines, including education, speech, audiology, language, sociology, and psychology.

Produced by the National Technical Institute for the Deaf (NTID) at Rochester Institute of Technology and published by the Association of Specialized and Cooperative Library Agencies, this resource provides the most up-to-date information for general reference and specific professional inquiry.

The work is available for \$35 from ASCLA Publications, American Library Association, 50 East Huron Street, Chicago, IL 60611.

"Rehab Brief" Surveys Nature of Future Work

"The Future of Work for People with Disabilities" is a *Rehab Brief*, Volume VIII, Number 2, that reviews a book by the same name, authored by Paul Cornes. The work was sponsored by the World Rehabilitation Fund, and it is available from them for \$5 (400 E. 34th Street, New York, NY 10016).

EIF Seeks Info On New Devices

The Electronic Industries Foundation Rehabilitation Engineering Center (EIF/REC) is interested in identifying new assistive devices, with and without electronic components, which could impact the lifestyle, productivity, and health of people with disabilities.

Responding to a national need identified by the National Institute of Handicapped Research (NIHR), the EIF established a nonprofit, NIHR-supported Rehabilitation Engineering Center. The center works to facilitate the transfer of promising new devices to the marketplace by stimulating private industry participation in their production and marketing. A primary goal is to increase the availability of safe, effective, reasonably-priced devices.

Individuals or organizations who have developed prototypes with broad applicability are invited to contact Robert Mills, 1901 Pennsylvania Avenue, N.W., Suite 700, Washington, DC 209006, (202) 955-5825. Proprietary information will be protected.

Suggestions should be limited to devices completed as working prototypes which are not already in production and which have not been licensed to a manufacturing firm.

The package should be of equal importance to handicapped people seeking attendant care or to prospective attendants. It can be used individually, in group instruction, or for the general public as an introduction to the importance and benefits that attendant care can provide to the handicapped population and with its ultimate benefit to the community at large.



How to Use Electronic Communications Effectively

Jack B. Ralph

Millions of Americans are being kept ignorant of services, benefits, and rights due them. Notwithstanding the good intentions of public and private agencies to serve the handicapped aging population, the present methods of communication exclude much of the target audience. This exclusion is rather on the side of "omission" rather than "commission."

When a document is designed or a campaign is developed to inform the public, little attention is paid to the ability of the handicapped person to see, hear, read, understand, and remember the information. Printed materials are produced by editors and publishers in type which is too small in size or unfamiliar in appearance, wrong colors of ink and paper are used, the paper is too shiny, and the sentences are too long, often complicated, using jargon and specialized vocabulary.

As long as people live in familiar surroundings with those people who understand them, they can communicate in any form or manner. Reductions in visual and hearing acuity, limitations on vocabulary and speaking ability, however, may have gone unnoticed, undiagnosed, or untreated for years. Upon becoming a member of the aging population, however, the person is forced to communicate and

respond to communication with agencies and institutions in the agency's language.

In spite of a great effort to hear and read important information, after a while, the effort and strain on this older population does not seem to be worthwhile. When this happens at whatever level, consciously or unconsciously, there is a change of attitude in the receiving population. There is a tendency by the person to withdraw from the society physically, at first, then mentally. For them, there is no point in trying. After a number of years, some people simply stop paying attention. Those people become virtually lost to society, to you and to your organization.

It is no wonder that information about the range of valuable activities of agencies, organizations, and service provided for the aging is generally unknown to many people who are in the most need of these very services.

Although it is the person's responsibility to learn to communicate effectively, responsibility also lies with agencies, organizations, and service providers to adapt to the needs of their constituency.

Much of the contact made with the handicapped and aging population involves public service announcements and special discussion shows on televi-

sion and radio. Just as in the use of the print media,¹ much of the information disseminated through the use of electronic media does not reach its intended population because efforts have not been taken to address the problems to sensory acuity.

Television producers also seem to be unfamiliar with the physical changes of aging when they develop and design the program visual formats, the use of color and contrast, position of the camera as it shows people speaking, and the use of print for visuals.

Many people do not see certain colors. Others need higher intensities of light on objects to see them. Many are deaf, hard of hearing, or have lost enough hearing to make complete understanding of the spoken word less than complete. The vocabulary in certain announcements may contain jargon, legalisms, and other words seldom used by the general population. Those people and recent immigrants are effectively handicapped in terms of information availability while they are learning our language.

Printed messages on the screen should have dark words or objects against a light background or light words or objects against a dark background so that objects and action on the screen are contrasted against their

background. A sofa should stand out against the carpet; a door should stand out against the contrast of the wall. If there is a need to show differences in the background, (water against the sand or grass, for example) variations in light reflectance should be used to adequately identify the visual contrast difference between the two areas. Viewing the images on a black and white monitor will give an indication of the effective contrast levels.

In consideration of colors choices, light blue, green, and blue-violet shades vanish into the white or light background of the sky or against white shirts. Red, pink and the oranges appear dark and are not good for the background for contrasting dark objects.

In the development of visual training films and tapes, editors find that the projection of lines of printing against a nice background is effective in summarizing or highlighting points made in the presentation. The message will be more effective when each letter of print is no shorter than one sixth the size of the screen, and when there are no more than three lines of information on the screen at the same time.

It is common for many people of all ages to say that they can hear better when they can see the face of the speaker, not realizing that they have lost some hearing acuity. Approximately 30 percent of spoken words can be "seen" by people with hearing problems. In viewing a television show, commercial, or a filmed presentation, these people also understand the spoken word better if they see the speaker. (In the case of a background narrator or "voiceover," the message is not heard or is not heard clearly.)

Many deaf and hard of hearing people read lips and spoken clues to enhance their understanding. Many older people who have lost some of their hearing acuity also rely heavily

on sight to read lips.

Many public service announcements use one visual message with elaborating narration in the background. People with hearing difficulties may receive only the information that they can see. Until recently, it was much cheaper to produce one page visual messages, hold them on the screen, and narrate the message. With the reduction in price of video tape cameras and the video cassettes, a more effective message can be produced at little expense by capturing a closeup of a person's face and lips as the message is spoken.

Because many people do not realize that they have lost some of their hearing acuity or will not use assistive hearing devices, it is better to show closeups of the speakers in video presentations and to avoid off-screen narrations.

Some television shows are produced in a "closed caption" medium. Printed messages and selected portions of the script have been transmitted to all television receivers on an electronic separate signal. These are similar to those used in the foreign film translations. An electronic device



or decoder is attached to the television receiver to receive this captioned message and project it on the bottom one sixth of the television screen. Only those people with decoders can see this closed captioned script. When the decoder is in operation, the message appears in a form similar to translations of the movie dialogue used in foreign films.

"Open captions," however, are messages or portions of the script that appear on the screen without the use of the decoder. These are also the same as those used in foreign film translations. Many older people also need the assistance of captioned dialogue when viewing the video or film presentations.

If there is enough concern for the effectiveness of the message and if there is just a little more money in the budget, open captioning of the video message is desirable and extremely valuable. Captions should be made open rather than closed, allowing everyone to read the message rather than restricting the captioning to people who have electronic decoding devices. Many deaf or hard of hearing people may have purchased decoders for closed captioning, but the persons who have not identified their need for assistive devices of any kind must still be served.

This recommendation does not preclude the continued use of closed captioning of entire productions for deaf and hard of hearing people whose need of captioning is more pervasive. The "opening" of captions would have the dual benefit, however, of making the message available also to these people who depend entirely on closed captioning to receive their telecommunications.

It should be remembered that proper captioning for those with hearing problems should demonstrate concern for those who also have vision

problems. The captioning should adhere to good practices in providing contrast. Light, white or blue letters or numbers, should be used only against dark backgrounds. Dark, red or black letters and numbers should be used only against light, white or light blue backgrounds. In many cases, it is advisable to make a dark edge or shadow around light letters and a light or white edge or shadow around dark letters.

In community rooms and classroom situations, it is advisable to boost the range of effective sound by adding remote speaker units in various parts of the room, installing auditory loops for people with hearing aids, or using special FM channel or infra red transmitters.

With aging, it also becomes difficult or even impossible to hear the higher sound frequencies. Men appear to have difficulty hearing their wives and grandchildren. People with high pitched voices who provide spoken information to the elderly cannot be heard clearly by their clientele. The use of mid-range horns and woofers in public address systems is more important than tweeters in the speakers.

There are many communication barriers, related to sensory acuity, memory, language and vocabulary, physical mobility, and cultural isolation. I have been directing my efforts toward identifying and recommending solutions. This discussion is a sample of the constructive remedies available to those who are in the business to disseminate information to all persons at all levels of endeavor. I solicit your questions, suggestions, and comments on efforts you have made in this matter.

Reference

1) Ralph, Jack B. Handicapped By Design: Need For Printing and Publishing Guidelines. *American Rehabilitation*, Mar-Apr 1982.

BEYOND BUREAUCRACY

(Continued from page 5.)

In documenting the process of her philosophy, Ms. Walker reveals the person that is Mary Switzer. She is complex: dedicated and serious minded (hard-nosed, when needed), caring and sensitive (never maudlin or fawning), yet visionary and inquisitive (incisive in fereting the extraneous to discover the real core of a problem). The book is important, then, in surrounding the person with the realities of the environment while never losing touch with the person within the maelstrom of political, sociologic, and scientific events of the world. Although Mary Switzer was fond of referring to herself and being recognized as "a bureaucrat," she never succeeded (perhaps never attempted) in concealing her basic humanity.

In his Foreword, Elliot Richardson says, "Mary Switzer's career was the career of a great bureaucrat. Such careers have seldom been scrutinized. We have many biographies of elected and appointed officials in the federal

government, but too few of great bureaucrats. This book makes an important contribution toward filling that void."

In closing, I relate an anecdote not taken from Ms. Walker's book but one which may succinctly summarize the quality of life coursing through her being. *Mary Switzer's mere presence made a difference.*

A friend told me that just before her death, he had gone to the hospital for a consultation. In answering a question from one of the nurses, he mentioned that he worked in HEW's Social and Rehabilitation Services.

"Oh," she said, "we just last week had one of your fellow workers here as a patient. . . Such a nice, compassionate person. Do you know that she was suffering a great amount of pain yet she always inquired about how I felt?"

"Who was that?" my friend asked.

"I think her name was Mary Switzer," she replied.

Mr. Bourgea is editor, *American Rehabilitation*.



If you find in **American Rehabilitation** the kind of material that informs or that is useful to you in some way, a colleague who does not receive the magazine may also profit by it. If you know such a person, fill out the blank below and send it to Editor, **American Rehabilitation**, Room 3525, 330 C street, S.W., Washington, D.C. 20201. We will be happy to send your friend a sample copy of the magazine.

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

PUBLICATIONS & FILMS

Foundations of the Vocational Rehabilitation Process. Second Edition. Stanford E. Rubin and Richard T. Roessler. University Park Press, 300 North Charles Street, Baltimore, Maryland 21201. 304 pages. \$21.95.

This second edition of a basic rehabilitation textbook has been thoroughly revised and expanded to provide a complete and authoritative introduction to the entire rehabilitative process. It provides university students with a basic overview and understanding of the historical, philosophical and theoretical foundations of rehabilitation practice and gives inservice counselors valuable information to help them respond to the multiple demands of vocational and independent living rehabilitation, including the legal expectations of recent rehabilitation legislation.

Handbook on the Late Effects of Poliomyelitis. Gini Laurie, Frederick M. Maynard, M.D., D. Armin Fischer, M.D., and Judy Raymond, editors. Gazette International Networking Institute, 4502 Maryland Avenue, St. Louis, Missouri 63108. 48 pages, \$5.

An estimated 300,000 people with some degree of disability survived the polio epidemics of the 1940's and 1950's. Their disabilities range from limited and localized muscle weakness to quadriplegia with total dependence on mechanical ventilation. The majority of these polio survivors have lived full and productive lives in their communities for over 25 years. Since 1979, many of them have reported new musculoskeletal problems resulting in fatigue, weakness, and pain. Many who fought hard to move without the aid of braces or crutches

now find themselves returning to the use of canes, braces, and wheelchairs. Others, weaned from a mechanical ventilator during the acute stage, are returning to the use of a ventilator for sleeping.

This handbook's practical dictionary format will be useful to polio survivors and physicians and other health care professionals treating a polio survivor for the first time. It contains information about the clinical problems associated with old polio based on the experiences of physicians and polio survivors. Topics include aging and weakness, arthritis, diet, exercise, frog breathing, hospitalization, misdiagnoses, muscle weakness, oxygen misuse, respiratory insufficiency, sleep apnea, tracheostomy, vaccines, and ventilators.

Functional Assessment in Rehabilitation. Andrew S. Halpern, Ph.D., and Marcus J. Fuhrer, Ph.D., editors. Paul H. Brookes Publishing Company, P.O. Box 10624, Baltimore, Maryland 21204. Hard cover, 288 pages, \$23.95.

This book offers a modern definition of functional assessment and seeks to close the gap between assessment and rehabilitation. Reports are provided on a variety of new instruments and procedures developed from current research in the field designed to improve the evaluation of rehabilitation patients and rehabilitation programs and will assist in therapy planning, psychology evaluation, vocational and educational assessment, and the management of rehabilitation research. The role of functional assessment in the areas of physical impairment, mental retardation, psychiatric impairment, and communicative

disorders is highlighted. Included is a brief history, an analysis of the present, and a projection about the future needs and developments in the field.

Library and Information Services for Handicapped Individuals. Second Edition. Keith C. Wright and Judith F. Davie. Libraries Unlimited, Inc., P.O. Box 263, Littleton, Colorado 80160. 184 pages. \$20.00.

This book includes a new discussion of services for the speech-impaired individual; defines major handicapped groups; reviews legal decisions and implications; presents ideas for library programs and services; identifies sources of information; outlines problems facing handicapped populations, solutions and the library community's resources and programs; and enumerates programs and services which librarians can modify to meet needs in their particular settings.

Behavioral Approaches To Rehabilitation. Coping With Change. Volume 3. Elaine Greif, Ph.D. and Ruth G. Matarazzo, Ph.D. Springer Publishing Company, 200 Park Avenue South, New York, New York. 10003. 158 pages. \$16.95, hardcover.

As the final volume of a three part series, this book homes in most specifically on the client as it considers the specific patterns of behavior of people who are depressed, anxious, demanding, unmotivated, brain-injured, disoriented, aged, and young. These conditions are examined against the backdrop of rehabilitation and an understanding of behavior patterns. Finally the book returns to the professional and family caretaker perspective to discuss stress management.

The appendices discuss charting progress, scheduling a routine, relaxation training, and a section on resources.

Notes on the margin...

FORMER RSAer HONORED

Dr. Boyce Williams, who headed the Communicative Disorders Branch of the Rehabilitation Services Administration for many years, is among five persons inducted into the National Hall of Fame for Persons with Disabilities. The induction was made at a seminar entitled, "The Unfinished Business of Equal Access" on October 26 in Columbus, OH. The other inductees were Anne Helen Carlsen, Almo June Reaves, Glyde C. Berger, and Alan J. Farber.

REHAB AUTHORS

The Author's Handbook: A Guide to Professional Journals in Rehabilitation, published by D:ata Institute, is designed to assist potential authors of articles in rehabilitation and related fields to identify journals interested in their topical areas. For each journal, the following categories of information are among those listed: preferred subjects, preferred article types, style guidelines, review procedure, review time, percent of manuscripts received which are published, and early publication policy. Additional information is available from Freddi Karp, D:ata Institute, The Catholic University of America, 4407 Eighth Street N.E., Washington, DC 20017, (202) 635 5826.

SPI AND PREGNANCY

Gazette International Networking Institute (G.I.N.I.) which publishes Rehabilitation Gazette, is gathering material for a handbook on the experiences of spinal cord injured women with pregnancy and delivery. The editor would appreciate contributions from around the world. Send material to: G.I.N.I., 4502 Maryland Avenue, St. Louis, MO 63108.

DISABLED FARMERS

Breaking New Ground is a newsletter for farmers with physical disabilities. Write to Department of Agricultural Engineering, Purdue University, Agricultural Engineering Building, West Lafayette, Indiana 47907.

MEETINGS, ETC.

. International Association of Psychosocial Rehabilitation Services, "Breaking Barriers - Building Bridges," June 3-7, Cleveland, Ohio. Call (216) 721 3030.

. Workshops, "Selection and Application of Microcomputers For Handicapped Individuals," March 7-8 and April 11-12, University of Wisconsin, Trace Research & Development Center, Waisman Center, 1500 Highland Avenue, Madison, WI 53705-2280.

. Founding Congress of the World Rehabilitation Association for the Psycho-Socially Disabled, Vienne, France, October 15-18. Contact Sheila Dekel, World Rehabilitation Association For The Psycho-Socially Disabled, P. O. Box 898 - Ansonia Station, New York, NY 10023, telephone, (212) 628 4469.

RECREATION OPPORTUNITIES

. Sign interpreters for individuals with hearing impairments are now available at Broadway shows in New York City. In addition, reduced tickets are available. For more information, contact the Theatre Development Fund, 501 Broadway, Rm. 2110, New York, NY 10003 or call (212) 221 0013.

. The National Park Service system offers a Golden Age Passport for persons 62-and-over and a Golden Access Passport for blind and disabled persons of any age. They exempt the holder from entrance fees and provide a 50 percent discount on user fees in any federal recreation area. Obtain in person from the National Park Service. For more information contact Ray Bloomer at (617) 223 2416.

. The "Quad-bee" is a frisbee modified with two adaptive clips. It was designed by Foster Anderson and a patent is pending on the item. Anderson also heads the Shared Adventures outdoor club for handicapped persons. Members enjoy activities such as sit-skiing, canoeing, and rock climbing. Anderson can be reached by writing 190 Norman Road, Rochester, N.Y. 14623.

HIRE HANDICAPPED PEOPLE: IT IS GOOD BUSINESS.

Computer Assisted Job Placement: Selected Applications

Fong Chan, Ph.D., Paul S. McCollum, Ph.D.,
and Harry J. Parker Ph.D.

The development of large scale integrated circuit technology in the past decade has enabled computer manufacturers to condense the main component of the computer, the central processing unit (CPU), very inexpensively into a silicon chip smaller than a postage stamp.¹ This technological breakthrough has resulted in a proliferation of low cost and, yet, powerful mini-/and microcomputer systems. They can perform complex electronic computing functions that once required costly and large mainframe computer systems.

The same technology has facilitated the development of super performance mainframe computers. These have made possible telecommunications, computer networks, office automation, and distributed processing systems.² The widespread availability of computer-telecommunication technology to the public could ultimately change the way American workers perform their jobs. As already observed by Naisbitt,³ the United States is moving rapidly from a manufacture-based to an information and service-based economy.

Undoubtedly, all these changes could have a significant impact on rehabilitation in general and the job placement of disabled workers in particular. For example, in an electroni-

cally wired society,⁴ the physical confines of work would not be as rigid as traditionally defined. A case in point is the HOMEBOUND program, sponsored by the Control Data Corporation, which gives disabled workers the flexibility of working at home by using a computer terminal.⁵ This movement towards telecommuting and flexible work place could lead to expanded employment opportunities for disabled people.

Rehabilitation professionals potentially could also benefit from this recent development in microelectronic technology. Papers discussing computer applications in rehabilitation counseling, vocational evaluation, work adjustment, and job placement have already emerged in the rehabilitation literature.^{6,7,8}

This paper's purpose is the discussion of selected computer applications in job placement with a focus on office management, vocational guidance/job-matching, and job bank development.

Office Automation

A major barrier to job placement reported by rehabilitation counselors is the lack of time available to perform this function.⁹ A major reason for the time reduction problem is that case management/paper work consumes a

large portion of rehabilitation counselors' work day. One way to improve management and office productivity is computerization. In rehabilitation settings for instance, similar client information may be required on various reports (*e.g.*, client contact report) and forms (*e.g.*, R-300 related data). With the help of integrated software (*i.e.*, a collection of word processing, database management, statistical analysis, and spreadsheet/budgeting programs), client information would be entered into the database only once. The same information can be retrieved again and again for writing different reports and generating forms.

The appropriateness and benefits of using the computer to improve counselor productivity in the areas of word processing, database management, financial and program planning, and electronic communication have been discussed elsewhere.¹⁰ For the purpose of this paper, the concept of calendaring that is germane to job placement will be discussed in detail.

Calendaring. A rehabilitation counselor spends a good portion of his time identifying job openings, contacting employers, providing followup and support services to clients and employers (*e.g.*, affirmative action plan, employee-assistance program), and coordinating a range of placement support

services (*e.g.*, transportation, job accommodation, and job-seeking skills training). However, to be successful by agency standards, the counselor must systematically schedule his time for these contacts. A computer calendar program can be a valuable tool to the counselor in this regard. For example, the counselor can store and assign priority to a comprehensive list of area employers for potential contacts according to categories of industries, types of business, location, and size, etc. Then, the time blocks available per week for employer contacts are entered into the computer. Accordingly, the computer will distribute the counselor's weekly employer contacts optimally, generate a courtesy letter in advance and a thank you letter afterward, and remind the counselor daily of the upcoming contacts. The same concept can be applied to client contacts (*e.g.*, followup), visits with community agencies (*e.g.*, state employment services), and tracking of overdue service reports from vendors (*e.g.*, job seeking skills training progress report).

Vocational Information

The quality of job placement is determined early in the exploration and planning phases of the vocational rehabilitation process.¹¹ To facilitate vocational decisionmaking, a rehabilitation client must be exposed systematically to the world of work; develop insights for skills, abilities, interests, and physical limitations; and be sensitive to labor market constraints.

Computer Assisted Vocational Guidance Systems. Historically, computer-assisted vocational guidance systems were developed for guidance and counseling with high school and college students. The early systems were sponsored by the federal National Occupational Information Coordinating Committee (NOICC) and

the state committee (SOICC) established under the Educational Amendments of 1976 (PL94-482). In general, most of the systems follow Parsons career guidance model¹³ which include client appraisal (values, interests, and abilities), information about vocational options, strategies for decisionmaking, and planning for appropriate action. Most systems contained Dictionary of Occupational Titles (DOT) based occupational information. In addition, a combination of different files of information on educational and training programs, educational institutions, employment trends, and sources of financial aids and miscellaneous information are available.¹⁴

Occupational information can generally be obtained by direct access or by structured search. The direct access (batch) method is usually used in searching for occupational information (*e.g.*, job definitions according to the DOT). In many personal microcomputer based systems, it may not be practical to store large amounts of pages of printed materials (*e.g.*, the Occupational Outlook Handbook) on floppy disks for computer display. Instead, the computer will simply direct the user to off-line printed materials (with exact volume and page number, etc.) that accompany the computerized guidance system.

In structured search (an interactive/conversational process), the client would communicate interactively with the computer. The client would present different combinations of job search variables (*e.g.*, interests, abilities, values, educational level, physical demands, and salary) in terms of likes and dislikes to the computer (occupational appraisal can be done on-line or off-line). The computer will search through its occupational information database to identify occupations that meet the client's different selection criteria.

By interacting with the computer to manipulate different job variables in a structured job search, the client could eventually learn to develop realistic vocational objectives. The interactive search process could also help the client identify strategies required to accomplish vocational goals.

Some of the better known vocational guidance information systems are: Computerized Heuristic Occupational Information and Career Exploration System (CHOICES, originally developed by the Canadian Employment and Immigration Commission), DISCOVER, Coordinated Occupational Information Network (COIN), Guidance Information System (GIS), System of Interactive Guidance and Information (SIGI), etc. Information on these systems can be found in the American School Counselor Association's monograph on microcomputers and school counseling.¹⁵

However, limitations of these current vocational guidance systems should be considered carefully. As noted, most vocational guidance systems today were developed for counseling in high schools and colleges. Hence, their reading level requirements tend to be fairly high and they tend to have an orientation toward professional occupations. More critically, they generally lack the specificity and flexibility for manipulating the physical demands variable in the job search.¹⁶

In addition, sometimes, the DOT based occupational information derived from these systems does not relate meaningfully to the local economy. It is only recently that some system designers have begun to attend to the problems of vocational guidance systems as they relate to rehabilitation. As an option, many system developers are helping customers build local files (*e.g.*, employer file and special training school file) into the search

structure of their systems.

Computerized Job-Matching Systems. While the aforementioned computer-assisted vocational guidance systems were designed for vocational exploration and counseling, job-matching systems tend to have a more direct job placement orientation. The two most well-known computerized job-matching systems in rehabilitation are the Computer Assisted Vocational Rehabilitation Counseling Technique (VOCOMP) and the Ability Information System (AIS).¹⁷ Both are mainframe computer based systems.

Access to these large databases is through a communication modem with a dial-up computer terminal or personal microcomputer. In the case of the VOCOMP, a batch option is also available. The user will have to fill out a standardized VOCOMP data sheet and mail it to the vendor. Because of the rehabilitation placement orientation of these systems, they tend to be strong in the areas of physical capacity, transferrable skills analysis, and employer identification.

A typical data base structure for these systems would include a combination of the following files: local employer contact file (for job placement counselors), assistive devices file, DOT titles/codes, job analysis, worker trait information, local employers (manufacturing and services, employer directories), local labor market trends, salary surveys, and local training sites (class schedules and catalogs). However, local information may not be available in every state and city in the United States.

In general, these systems are used for more specific purposes (*e.g.*, to further validate information derived from vocational exploration and counseling). The degree of direct client involvement with the computer is less here than with interactive voca-

tional guidance systems during the vocational exploration phase.

Finally, potential users must exercise caution when using these systems. As pointed out by Botterbusch,¹⁸ the appropriateness of computer job search output depends largely on the reliability of the input data and the validity of the internal (computer) job search algorithm. In appealing to a broad base of customers, some programs opt for flexibility of input data at the expense of accuracy. By design, these computer programs may be subjected to multiple sources of uncontrolled error variance. For example, there are significant differences between data obtained as the result of a week of vocational evaluation and the result of crude estimates based on little more than guessing.¹⁹ Even the substitution of test results obtained from one particular test (*e.g.*, the GATB) with another similar test (*e.g.*, the DAT) may confound the outcome of the job search results. Interested readers are referred to Botterbusch's 1983 monograph on computerized job-matching systems for a thorough discussion of this subject.

Job Bank Development

In a comprehensive review of job placement methods, Dunn²⁰ suggested that friends, relatives, and acquaintances are one of the most effective means of obtaining a job. Because of their disability and reduced social contacts, rehabilitation clients tend to lack direct access to these private and informal job availability networks. Dunn concluded that counselors who are effective in job placement may have developed an informal network of job informants to compensate for their clients' deficiency in this area of the job search process. Therefore, one recommendation for improving job placement is to establish regular and systematic procedures for counselors

to pool informal local employment information. Obviously, it makes sense for counselors to share an extended network of job informants because, by doing so, they would have expanded choices of job openings to match the qualifications and needs of their job-ready clients. However, in order for counselors to participate in this kind of job placement information exchange, the procedures for pooling information must be extremely easy and convenient for them.

The concept of an electronic job opening bulletin board (which already exists in the computer hobbyists circles) can be used precisely for this purpose. A counselor or client could be selected to be the operator of the electronic job opening bulletin board. He would be equipped with a powerful microcomputer, appropriate information storage devices (*e.g.*, a hard disk), and communication hardware/software.

The volunteer counselor's microcomputer will be designated as the host computer for the job opening bulletin board. Local job opening information would be posted electronically by participating counselors from their own microcomputers to the host computer on a routine basis and can be shared immediately by counselors and clients. Once the system has become operational, historical job opening data can also be used as information for potential employer contact and can be retrieved for job development purposes. This similar concept has been implemented on a mainframe computer as a demonstration project by the Georgia DVR with encouraging results.²¹ However, with the proliferation of microcomputer technology, operating a microcomputer-based local job opening network may be more flexible and practical for keeping information current and meeting local counselors' needs.

Implications

It has long been argued that job placement should be regarded as a program goal instead of a discrete set of activities (helping clients find jobs) that occur in the final stage of the rehabilitation process.²² Quality job placements result only from quality vocational assessment, counseling, and planning services in the early rehabilitation phases. Computer applications (in vocational guidance and job-matching) could help provide the essential occupational and personal needs information for sound client vocational decisionmaking.

By developing a realistic and attainable vocational plan, the probability for achieving a successful job placement outcome will be increased. In addition, office automation can free counselors from mundane paper work to engage in professional job placement activities. Electronic information networking will provide counselors with timely job placement information.

It appears that with the help of today's computer technology, rehabilitation counselors may stand to improve both the quality and quantity of their job placements.

Dr. Chan is assistant professor, Dr. McCollum is associate professor and director of the graduate rehabilitation counseling program, and Dr. Parker is professor, Department of Rehabilitation Science, the University of Texas Health Science Center at Dallas. A portion of this paper was presented by Dr. Chan at the RSA Region VI Annual Rehabilitation Education and Training Seminar, Dallas, June 1, 1984.

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Working Together: Disabled People And Their Attendants Talk About Attendant Care. Slide-tape production, 10 minutes; print manual; the package contains a prepackaged carousel slide tray, a cassette tape, and a printed script and manual. Access to Independence, Inc., 1954 East Washington Avenue, Madison, WI 53704. \$175 plus \$4.50 postage and handling.

The Consumer's Guide To Death, Dying, and Bereavement. Roger Shipley. ETC Publications, P.O. Brawer ETC, Palm Springs, California 92263-1608. 250 pages. \$14.95 hardcover; \$7.95 softcover.

For a state so universal, there has been, until recently, little resource and recourse both for the dying person and those left to confront the passing. This book confronts all aspects of the subject, from the personal, religious, and legal to cost of dying and financial obligations once a person has died.

The appendices present a bibliography and a number of other informative entries, such as a directory of funeral and memorial societies and criteria for transplants.

Voice Activated Computer Used In Rehabilitation Training

John M. Williams

Keith Fires is 31 years old. He has muscular dystrophy. For most of his life he has dreamed of having a full time job with the benefits that come with it—paid vacations, medical care, paid holidays, raises, responsibilities, etc. He has spent much of his teenage and adult years working to achieve his dream. He has a high school diploma and a degree in mathematics and computer science. He received the degree in 1978 from Cypress Community College in California.

In August 1984, Fires completed a rehabilitation training program at Goodwill Industries in Santa Ana where he learned to use CASH (Computer-Aided System for the Handicapped), a voice activated computer system.

"I searched for a long time for the proper technology to help me with my education and in securing a job. CASH is that tool. It has and will open up a career for me," Fires said.

Last year, he was introduced to CASH through a friend of his, Jan Oliver. She was a rehabilitation computer trainer at Goodwill Industries. She had been trained on CASH by Arnold Balliet, products manager, Cascade Graphics Development. Cascade manufactures and distributes CASH.

"I was trained for about 6 weeks on CASH. It was my first introduction to a computer. I found it to be the best instrument in the computer technol-

ogy area for disabled people such as Keith Fires, who cannot use their arms and hands, but who are capable of giving voice commands," said Oliver.

Training

Fires started his training in July and it ended 6 weeks later. He spent 20 hours learning how to operate CASH. (His instructor was sick during much of the training time. This was the reason it took 6 weeks.)

"There were four steps involved in my training. They included creating a vocabulary, teaching CASH to learn my individual vocal characteristics, testing the voice patterns for accuracy, and, finally, starting recognition of my voice patterns files that allow CASH to compare the voice patterns created during my training with the words I speak," said Fires.

He was a rapid learner as he proceeded from step one through four.

Step 1. Creating a vocabulary. Fires had to decide on the spoken words and then key replacements and then create a script using the first option on the Voice Utility Program (VUP) menu — Build and Edit Vocabulary.

The script tells CASH what is going to be said and what to do—that is, which keys to press when each word or phrase is recognized.

"To build a script, I had to tell CASH the words I would use to give commands. These spoken words are

collectively called the training words of the vocabulary. Associated with each spoken word is a set of keys to press. Of course, the system needed to know the words associated with key placements. I accomplished this task simply by listing the spoken word and key replacements on the same line and using a semicolon to replace them," said Fires.

Step 2. Giving CASH the same word 5 times. "In this step, CASH is being trained on how each of the words in the vocabulary sounds. The system needs multiple repetition to make sure it heard correctly. The multiple repetitions, called training passes, allow any words that I might have mispronounced to be corrected," explained Fires.

Step 3. Testing the voice patterns for accuracy. On this area, Fires said, "The voice patterns are a rough approximation of the complex sounds in speech. Mispronouncing a word or being interrupted when training may cause the creation of a bad voice pattern. Testing will find any voice pattern that allows retraining of that one word.

Step 4. Starting the recognition of the voice pattern files. "This allows the system to compare the voice patterns created during training with the words being spoken. When a match

occurs, the key replacement for that word is entered as if those keys were being typed on the keyboard."

He simplified the training program. Although both he and Oliver believe the system is not very difficult to master, it requires determination, thought, and practice. He learned to operate the system in 20 hours. Others have done it in 8 to 10.

"There is more to the system than I have described, of course. For example, the system also offers environmental controls that will allow me to control my work environment when I start working for Goodwill Industries very soon as a data entry person," stated Fires.

Using CASH, Fires job skills are expanded to include word processing, accounting, data base management, programming, journalism, telemarketing, and other fields.

Environmental Controls

In addition to all the usual computer functions, the system controls the environment and the equipment around the person using it. This can include air conditioning/heating, telephone (dialing, answer, and hangup), solid state relays (turning pages, positioning an electric bed, opening and closing windows, turning lights on and off or dimming and brightening them, and activating other appliances, such as a stereo and television. It can even open and lock doors.

The environmental program runs in the background of the system. An example of how Fires has been trained to use both the environmental and working programs is his being able to stop a word processing function to answer the telephone simply by saying, "Toggle interrupt" and then, "Answer phone." In this situation, the working program stops and the phone is answered. Fires can talk for as long as he needs and then return to the word

processing function by saying, "Hang-up" and then, "Re-enter."

"This convenient feature gives me enhanced comfort since environmental adjustments can be made at any moment. If I want to stay solely in the environmental control program, I can. This means, for example, if I want to relax, I can have the stereo on for background music, the air-conditioning unit on, and the lights at the brightness I want all while reading. I do all this by voice control. What a relief! What a great feeling of independence this gives me," said a smiling Fires.

CASH is easy to operate. It operates in DOS (Disk Operating System—a computer operator system used with disk drives), CP/M (Control Program for Microcomputers—a widely used operating system developed and sold by Digital Research, Inc.) and Pascal—software used primarily in the mathematics area.

The system also comes complete with installed Wordstar—a word processing package—and Supercalc electronic spreadsheet software and documentation. (Spreadsheet displays data in chart form while showing the effects of variables.)

Other features of the system include: 128K RAM (Random Access Memory is data that can be easily ac-

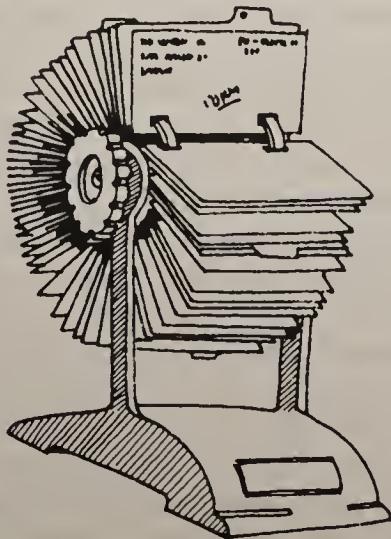
cessed, altered and unfortunately lost when the power is interrupted); 10 MB (Megabyte) hard disk memory; a 5 1/4" floppy disk drive is used to input additional programs and make backup disks; dot matrix printer; speaker phone and modem; headset or free standing microphone; television controller and tuner; and an adjustable tilt and turn 12" non-glare monitor with easy-on-the-eyes raster monochrome screen with 280 x 192 resolution screen.

"Technology is the great equalizer for disabled people. We need more access to it. We need the opportunity to show what we can do with it. Business and government should make it accessible to us. It benefits them, us, and the country now and in the future," said Fires.

Fires adds, "I am lucky to have been trained on this voice activated system. Goodwill has an excellent program. I believe other disabled people are going to be trained on it. Goodwill has taken a lead in this area. Its rehabilitation program has been designed to help disabled people like me to build better and more productive lives. Someday I am going to be a computer programmer working in industry. I believe my dream is about to become a reality. I hope other disabled people are as lucky as I have been."

In the future, Fires wants to return to college and take more courses in computer science and mathematics. (He tutors students from grades 7 through college in mathematics now.) He needs CASH to help him advance his education. He needs the education to advance his career. He believes he will succeed. His friends and family believe it, too.

Mr. Williams writes frequently about computer usage among handicapped people. He is President, Technical Communications, Sterling, Virginia.



REPORT RESOURCES

SOCIETAL PROVISION FOR THE LONG TERM NEEDS OF THE DISABLED IN BRITAIN AND SWEDEN RELATIVE TO DECISION MAKING IN NEW-BORN INTENSIVE CARE UNITS. Rev. Ernlé W.D. Young, Ph.D., Monograph #25, World Rehabilitation Fund International Exchange of Experts and Information in Rehabilitation, 1984.

On the basis of his 30-day study-visit in Sweden and the U.K., Dr. Young makes recommendations to our own neonatal intensive care teams, to parents of disabled children, and to those responsible for shaping public policy. To do for the disabled what is being accomplished in Britain and Sweden would require a radical restructuring and reordering of our society after the socialist model. Given the value placed on individual autonomy and our free enterprise system, such a drastic response to the problems of the disabled is unlikely. However, his recommendations include some practical steps which might be taken to raise our standard of caring for the disabled which would be somewhat closer to the British and Swedish programs.

The monograph contains additional commentaries by B. Persson, Department of Pediatrics, Karolinska Institute, Stockholm, Sweden; A.G.M. Campbell, Professor of Child Health, Aberdeen, Scotland; Mary Jane Owen, MSW Disability Advocate, Information Specialist, PCEH; Nat Hentoff, Civil Liberties Columnist, Village Voice, Washington Post; Harlan Hahn, Professor of Political Science, University of Southern California; and Thomas Nerney, Consultant to the Office of Special

Education and Rehabilitative Services (U.S.D.O.E.) and Founder and Secretary of "Operation Real Rights."

For copies contact: John King, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

INDEPENDENT LIVING AND DISABILITY POLICY IN THE NETHERLANDS: THREE MODELS OF RESIDENTIAL CARE AND INDEPENDENT LIVING. Gerben DeJong, Ph.D. (Monograph #27) World Rehabilitation Fund, International Exchange of Experts and Information in Rehabilitation, Spring 1984.

The American independent living (IL) movement has focused on the IL center as the principal coordinating vehicle by which people with disabilities can, through self-advocacy and self-help, organize the various housing, transportation, and attendant care services they need to live independently in the community. The Dutch system by contrast has focused on a 3-part network of quasi-residential and IL programs, often under private sponsorship, but more firmly linked to the nation's various entitlement programs.

There is no such thing as an IL center in the Netherlands. This is not to suggest that the disability rights movement in the Netherlands is at an arrested state of development. Rather it reflects the fact that the IL needs of disabled Dutch citizens have been more readily embraced by Holland's mainstream entitlement programs.

This monograph critically examines how Holland's 3-part system of residential care and independent living is wedded to the country's mainline health and social welfare systems giving due consideration to the larger economic, social, and political context in which Holland's various programs have emerged.

For copies contact: John King, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

PRODUCTIVITY AND COMFORT OF THE VISUALLY IMPAIRED WORKER AS A FUNCTION OF LOW VISION AID USAGE AND ILLUMINATION/COLOR CONTRAST MODIFICATIONS. Executive Summary (NIHR-G008103981) RTC in Blindness and Low Vision, Mississippi State University, August 1984.

The focus of the research and training of the Rehabilitation Research and Training Center on Blindness and Low Vision in the development of strategies which might be used by rehabilitation professionals and consumers to enhance the career development, and hence, the employability of blind and severely visually impaired persons. The development of a technique which might assist the severely visually impaired person to make better use of residual visual functioning on-the-job in one career development enhancement strategy under investigation. The technique under investigation is the effect of changes in illumination levels and color contrast on the productivity of severely visually impaired workers who may or may not use low vision aids. If increases can be made in a worker's visual functioning through low vision aids

and work environment modification, then it may be anticipated that this is a strategy which might be used by consumers and professionals to enhance the employability and career development of severely visually impaired people.

Implications for career development enhancement practice are presented: individualized testing for establishing illumination levels optimally needed by the partially sighted worker should be done; frequent testing is appropriate for individuals with progressive eye conditions; testing for optimum environmental enhancers should be job specific; specific environmental modifications should be strategically devised and refined; where feasible, flexible illumination and color modifications should be incorporated.

For copies contact: John King, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

THE FOUNTAIN HOUSE MODEL: A SOCIAL INVENTION IN COMMUNITY REHABILITATION OF THE MENTALLY ILL. Proceedings of an International Seminar, November 1981.

This volume contains the proceedings of an International Seminar—the Fountain House Model—*A Social Invention in Community Rehabilitation of the Mentally Ill*, held at Lahore, Pakistan from November 12–16, 1981.

The seminar described the development of the Fountain House concept as a social invention in the rehabilitation of the mentally ill and its functioning in different geographical settings. It is divided into eight working sessions: The Fountain House model;

the prevocational day program; a program of transitional employment; the social-recreational and residential programs; member leadership in the clubhouse model; clubhouse accountability; open session; and trans-cultural dissemination of the Fountain House model.

For copies contact: John King, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., the Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

AIDS FOR ELDERLY PERSONS WITH IMPAIRED VISION. *Aids and Appliances Review*, The Carroll Center for the Blind, Issue No. 13, Summer 1984.

the lead article, "Vision from an Aging Perspective," discusses the functional limitations that occur with common causes of vision loss in older people. It provides an empathetic model of how the world is viewed through the eye subject to cataracts, macular degeneration, visual complications from diabetes, and glaucoma.

"Making the Environment More Visible for the Elderly Visually Impaired" discusses components of the home environment that can cause difficulties, and it outlines the three approaches to solving typical problems: more effective use of lighting, increased size of objects and images, and enhanced contrast.

The *Resource Guide* compiles and evaluates products useful as aids in activities of daily living. A list of useful books and manuals is included.

The article, "Helping the Visually Impaired, Elderly Person," follows the *Resource Guide* and examines the characteristics of old age and how they will influence approaches to providing assistance. The issue concludes with a selected bibliography.

For copies contact: John King, National Rehabilitation Information Center (NARIC), 4407 Eighth Street, N.E., The Catholic University of America, Washington, D.C. 20017. Contact NARIC for price assessment (202/635-5822, TDD 202/635-5884).

HEALTH GROUPS IN WASHINGTON; A DIRECTORY. National Health Council, 70 West 40th Street, New York, NY 10018.

INDEPENDENT LIVING AND POLICY CHANGES; REFLECTIONS ON A DECADE'S PROGRESS. ILRU Project, P.O. Box 20095, Houston, TX 77225. \$5.

CHARACTERISTICS OF THE HANDICAPPED POPULATION IN THE UNITED STATES: A report based on the 1978 survey of disability and work. Center on Human Development, University of Oregon, Eugene, OR 97403.

CATALOG OF PUBLICATIONS 1984. National Association of the Deaf, 814 Thayer Avenue, Silver Spring, MD 20910.

YUGOSLAV SELF-MANAGEMENT IN REHABILITATION. Final report to the World Rehabilitation Fund on study-visit relating to NIHR priority: "Improving Rehabilitation Management." Carolyn L. Vash, Ph.D. World Rehabilitation Fund, Inc., International Exchange of Experts and Information in Rehabilitation, 400 East 34th Street, New York, NY 10016.

MEDICOSOCIAL WORK AND NURSING: THE CHANGING NEEDS. EURO reports and studies 79. World Health Organization. WHO Publications Centre USA, 49 Sheridan Avenue, Albany, NY 12210.

Spinal Cord Injury Research: Separating Fact From Fiction

J. Paul Thomas, Ph.D.

The National Institute of Handicapped Research announced the availability in 1984 of 3.5 million for support of a new program of field investigator initiated research. Three hundred and seventy four applications were accepted for scientific-technical review. Eighty four were assigned to the Medical Sciences Office with 28 having a specific focus on Spinal Cord Injury. Of the 84, 27 or 32 percent of the applications were recommended for approval by one of six medical research review panels. Following scientific methodological evaluation, 11 project applications were recommended for award, an approval rate of 13 percent. Five of these projects focused on spinal injury research.

Many of the excellent topics proposed were not adequately supported by appropriately rigorous methodologies and research designs. This paper presents an analysis and overview of the scientific review process and identifies major deficiencies noted by non-federal and professional staff reviewers as mitigating good scientific effort.

The presentation will provide a discussion of specific design and methodologic errors including sampling techniques, format and structure of study designs, research task phasing, and control of essential dependent and independent variables. Such attention

to detail by applicant organizations would significantly enhance the potential for their spinal cord injury research proposals to receive federal support.

The array of 36 scientific deficiencies noted in Table 1 strikes at the heart of separating "fact from fiction" in research activities. These errors may have a deleterious effect on results and findings rendering them meaningless, if not misleading. Clinical intuition alone provides for more objectivity and acquisition of balanced information than does poor research!

There is little that can be remediated of a poorly conceived research investigation. Faulty assumptions and poor research planning lead to incorrect scientific approaches and strategies. Thus, this effort begins as a wasted effort for both the research team and the reviewing scientists. Eight applications were observed to have this type of conceptual deficiency.

Lack of control of important variables in experimental and control samples accounted for five deficiencies worthy of disapproval. Because many medical and social scientific statistical research techniques use the rationale

Table 1

Scientific Deficiencies

Conceptualization/approach	8
Control of subject variables	5
sampling	3
methodology	10
grantsmanship	5
intervention	2
techniques	3
methods follow objectives/hypothesis	3
uncertain outcomes	4
quantification/evaluation	3
	36 (in 16 proposals)

of normal distribution and/or sample selection from identical populations for study of intervening variables, both internal and external validity is spuriously influenced. *Internal validity* raises the question "did the experimental stimulus make a significant difference in this setting?" *External validity* calls into question the representativeness or generalizability of the findings, *i.e.*, to what populations, settings, and variables can this result be generalized? Both criteria are important although not completely compatible, in that controls required for internal validity may jeopardize representativeness or generalizability.

Two proposals reflected significant sampling deficiencies. The issues here were improper sampling techniques and inadequacy of subjects for meaningful statistical results.

Methodologic deficiencies were noted in 10 proposals. Further inspection of reviewer comments indicated five applications were deficient in the discussion of specific techniques to be used, two proposed inappropriate or questionable experimental modalities, and three demonstrated errors in methodologic conceptualization of the modalities under investigation.

In three proposals, investigative methods did not follow the hypotheses to be tested. Either hypotheses were without appropriate methodology for investigation or major elements of the methodology did not reflect originally stated research objectives or hypotheses.

Improper techniques and methods for quantification and evaluation of subjects following experimental intervention or the inadequate measurement of baseline characteristics of E&C samples accounted for three rejections. Either fault diminished the meaning of the results because the very phenomenon being investigated is not adequately measured and confi-

dence is not assured that both E&C samples are drawn from the same population/distribution.

The uncertainty of useful results was demonstrated in four proposals either through limited description of how the findings would benefit or enhance the acquisition of new knowledge or the investigator did not appear to have a strategy for what use would be made of the results.

These several significant errors of omission and commission in describing, planning, and conducting research clearly made the difference in opportunities for federal grant sup-

port. But more importantly, what if these projects were initiated anyway? What would be the benefit and effect of the results on clinical decision making and provision of services? While excellent research naturally leads to and enhances excellence in patient care, poorly executed investigations generating faulty data may have deleterious effect on the quality of care and the efficiency of physical restoration and rehabilitation.

Dr. Thomas is Director, Medical Sciences Programs, National Institute of Handicapped Research.

Emotional Rehabilitation of Physical Trauma and Disability. David W. Krueger, M.D., editor. SP Medical and Scientific Books, a division of Spectrum Publications, Inc., 175-20 Wexford Terrace, Jamaica, New York 11432. 292 pages. \$39.95.

This book contains 20 chapters by 23 authors, presented under 3 sections. Section I includes chapters which elaborate on the emotional response to physical disability, beginning with an overview on emotional rehabilitation and stress response syndromes. Section II examines specific areas of rehabilitation, including chronic pain, spinal cord injury, amputation, cerebrovascular accident, burns, deafness, and chronic disability. Section III deals with specific treatments, including brief psychotherapy, clinical social work, group therapy, sexuality and disability, subjective elements in rehabilitation, adjustment to long term disability, and special considerations in the geriatric patient.

Its organization emerged from daily therapeutic encounters which have at least as much of a basis in emotion and psychological make-up as in physical processes. The philoso-

phy and principles of emotional rehabilitation move from experimental and intuitive to greater objectivity and discussion so that nonpsychiatric physicians can integrate them into daily clinical practices. This book presents knowledge of behavioral science applied to physical illness and rehabilitation.

Part Of This World. 3/4 inch video cassette and 16mm. 28 minutes. Transit Medic, Inc., 779 Susquehanna Avenue, Franklin Lakes, N.J. 0417; telephone (201) 891-8240. Rental: \$45 for 3 days. Purchase: \$400.

This film shows how two parents learn to cope with, understand, and ultimately accept their child's deafness.

The 28-minute, color production features Ken Moses, a psychologist known nationwide for his counseling of parents of handicapped children. It is an excellent supplement to group parent counseling sessions and preservice and inservice teacher preparation programs. Although the specific handicap discussed is deafness, the film is actually an exploration of the psychological impact any handicap has on a family.

Language Used or Used Language?

Ron Bourgea

Superabundance. Sue these words for nonsupport.

- I read of programs that “*manage* and *administer* the *operation* of the rehabilitation facilities . . .” and thought that the author could better manage his writing by administering it to analysis, *i.e.*, they “*managed* the rehabilitation facilities” tells everything that he wanted to say since “manage” means administer and, when one manages a facility, its “operation” is understood.

The same organization wanted “to offer the most practical, direct, and *responsive training experiences* possible.” When training is given, there is a “response,” positive or negative, but, definitely, a response. And when training is given, it is already an “experience.”

This organization also had a “new and innovative” program, which is to say a “new-new” program. Very, very innovative innovation, indeed, indeed!

Is it any wonder that this organization made “presentations on a *wide* variety of rehabilitation topics”?

- *Inflated expressions*, which are *wearisome expressions*:

- 1) . . .met to discuss--discussed. If they discussed, they met.

- 2) The report is *intended to provide data* on. . . . The report provides data on. . . unless its intent wasn't

met.

- 3) “[They] have entered into an agreement to identify opportunities to jointly use selected expertise and resources to focus on the needs of older people.” “They have agreed to use resources for old people” (9 versus 24 words). A “resource” is “something that lies ready for use. . .” *Webster's*. That can include a “skill” (“expertise”), a “person,” or a “machine,” etc. The author here tries to make a nonexistent difference between an “expertise” and a “resource,” ostensibly the one being a process while the other is material. The differentiation, however, is strained, as it is in most of these types of artificial inseminations of language. Consequently, they self-abort in the face of reason.

“They have entered into an agreement” is nothing more than “they have agreed.” “Jointly” has no business in this joint since everything said in the sentence tells us that the operation is between two organizations. Finally, what is this business about “selected” expertise? Isn't it obvious that when one brings an expertise to bear on a problem or an area, that the expertise chosen would be “selected” as appropriate? Just wasted words! Which is just wasted time! Which causes frustration. Which just wastes more time. But it does create some-

thing--ill will. And grist for this column!

- “stimulating productive activity.” Activity always has a product. Does the author want to say “beneficial activity” or some such delineation? I think so.

- “. . .through educational and experiential programs.” Educational programs are an experience. Here, however, I think the author wanted to say “through educational programs and through other experiences.” The problem comes in trying to mix the specific educational programs with the more general and ill-defined “other programs.” Sometimes brevity can be confusing.

Careful Writing. Simple writing does not necessarily mean clear writing.

- *Bureaucratic Bias* (*Good words that become vogue and, consequently, vague.*) **Activity.** I have noticed a lot of activity in marrying (one might say, a marriage activity) the noun “activity” with another noun used as an adjective. When that marriage occurs, file for divorce. Here are some notables: sports activity equals sports; work activity equals work; and counseling activity equals counseling.

- *Compacting:* 1) *departmental* comments. A department, according to *Webster's*, is “a separate part, division, or branch, as of a government, business, or school. . . ; a field of knowledge or activity. . . ; a specialized column or section appearing in a periodical [an Americanism]; an administrative district in France. . . .” As such, the only department that can “comment” is the one under the “Americanism” definition—*e.g.*, this department (*Language Used Or Used Language*) is commenting on the usage. Otherwise, and it is used most often otherwise, it is used wrongly. “Comments from departmental staff have been received” is correct. It is the

staff which comments, not the department. Another example of where shorter is not always better!

2) "On February 16, the . . . Director participated in a panel on transition from school to work for blind and visually impaired at a conference sponsored by the American Foundation for the Blind at the Capitol Holiday Inn under an RSA training grant." The rambling quality of this sentence is bad enough, but the author makes it worse by tacking on the dangling phrase at its end. It reads that the Capitol Holiday Inn somehow receives an RSA grant which we know not to be the case. The phrase belongs after "Director participated." Even then, this sentence's quality would be improved by making this "second thought" a second sentence.

3) Compacting has its stylistic merit when tedious phrases are shortened, *e.g.*, advisory board for board of advisors and legislative council for council of legislators. Style runs amok, however, when the precept is overdone: a *grant application training session*—three nouns are converted to adjectives to modify the fourth noun. While the phrase is compacted, euphony and rhythm would be better served by rendering it as "training in applying for grants." (Incidentally, training *is* a session, so that the revision has the advantage of ridding ourselves of a useless word, in itself a form of compacting in its useful application!) Another example, extracted from a newsletter: "*Nuts and Bolts*. . . uses the *isometric projection exploded-view drawing concept* to teach assembly skills. . ."

James J. Kilpatrick, in his book, *The Writer's Art*, gives the quintessential example in his fifth injunction on what "We ought not do" in writing: ". . . he promises one day to write about the *modifier noun proliferation increase phenomenon article protest*

campaign success story, but he doesn't expect to write the piece any time soon." The emphasis is mine, and it underscores the nine nouns affixed to a tenth in a riot of the ridiculous.

Pastiche.

• *Down with UP.* In his book, *The Writer's Art*, James J. Kilpatrick, quotes Margaret Aspegren of Burr Oak, Kansas, who "says we *up* almost everything: A rider saddles *up*, a writer types *up*, vacationers close *up*, children clutter *up*, maids fold-*up* and make *up*, and in the bathroom we wash *up*. We warm *up* leftovers, lock *up* a store, start *up* a car, burn *up* waste paper, and fatten *up* a herd of cattle. Such upmanship should be pruned *up*."

Without OUT. For my part, I'd like to take out (remove) the use of "out" as a cop out (avoidance) in using better expressions. The exercise, you will find out (learn) helps you look out for (be alert to) better ways to bring out (express) the ideas you are trying out (suggesting to) on your readers. I need not point out (caution) that backing out of (retreating from) this endeavor is nothing more than blocking out (denying) a better way to sort out (list) to your advantage the positive methods of expressing yourself. Far out! (Nicely done!) (Fantastic!) (Etc.!)

• *Vigilance.* In reviewing one of my language columns, I noted that I, in reporting on Alice's Adventures In Wonderland, wrote that she was falling *down* the rabbit hole." It dawned on me that she wouldn't fall "up," of course, so "falling in" would have been more accurate. My regret in this matter is that the fault was not noted by a reader. . .

• "Absolutely free" is an advertising atrocity that ranks with its free gifts." There are no strings attached to "free." It is an absolute. Absolutely!

• *Totally* is another of those words (like "absolutely" and "very," as in absolutely free and very unique) which should draw your jaundiced eye. You see it often in expressions such as "totally consumed" and "totally devoted". The words qualified here are already totalities, and they only need limiting qualities when those are called for.

These kinds of "abundances" are heard most often in commercials. But the epitome of this usage was heard in a roach exterminating "hard sell" that guaranteed that the pests would be "killed dead forever." That, my friends, is "absolutely absolute" or, one might say, an "eternal finality!"

The Promised Land. The difference between the right word and the almost right word is the difference between lightning and the lightning bug. **Mark Twain.**

• "Americans don't like plain talk anymore. Nowadays they like fat talk. Show them a lean, plain word that cuts to the bone and watch them lard it with thick greasy syllables front and back until it wheezes and gasps for breath as it comes lumbering down upon some poor threadbare sentence like a sack of iron on a swayback horse." **Russell Baker**

• *Gobbledegook:* "When we let our prose go gobble-gobble-gobble, we turn out sentences that are turkeys." **James J. Kilpatrick** in *The Writer's Art*.

• Nouns and verbs always provide the core of language: choose them carefully. Every time you use nouns in the plural, *e.g.*, "solutions," ask yourself, "Do I mean all solutions? Or many? Or some? Or few? Or, as a matter of fact, just exactly how many? Beware of abstract and collective nouns. They frequently mean different things to different readers: they denote no one thing because they have too many connotations. They harbor

vagueness. They encourage evasiveness. They shelter irresponsibility. You can make effective use of one of the following adverbs before the verbs in scientific papers: *always, often,*

sometimes, or never. Such practice will sometimes improve your logic and reasoning, even before you reach the final draft.

To achieve real excellence you will

revise at least once and exclusively to eliminate uselessly repetitious words and phrases, or even sentences.

—Alan Gregg, M.D., *American Journal of Psychiatry*, Vol. 109.

PUBLICATIONS & FILMS

New Publications for which content reports are not listed follow. The name of and address of the publisher is given first, followed by the publication title and its price.

Human Sciences Press, Inc., 72 Fifth Avenue, New York, NY 10011.

The High Cost of Healing. Physicians and the Health Care System. J.H.U. Brown, Ph.D. \$26.95

Helping Skills II: Life Development Intervention. Leader's manual and Trainee's workbook. \$9.95 and \$12.95.

Rehabilitation Techniques. Vocational Adjustment for the handicapped. James S. Payne, Ed.D., Allen K. Miller, Ed.D., Robert L. Hazlett, Ed.D., and Cecil D. Mercer, Ed.D. \$16.95.

The Physiology Of Stress. With special reference to the neuroendocrine system. Mary F. Asterita, Ph.D. \$14.95.

The Overeaters. Eating styles and personality. Jonathan Jurland Wise, M.D. and Susan Kierr Wise. \$14.95.

Tavistock Publications, Methuen, Inc., 733 Third Avenue, New York, NY 10017.

Social Learning & Change. A cognitive approach to human services. Howard Goldstein. \$12.95.

Dealing With Drug Misuse. Crisis intervention in the city. Anne Jamieson, Alan Glanz, and Susanne MacGregor. \$12.95.

Brookfield Publishing Company, Inc., Old Past Road, Brookfield, VT 05036.

Caring For Unemployed People. A

study of the impact of unemployment on demand for personal social services. \$12.00

The Haworth Press, 28 East 22 Street, New York, NY 10010.

Handbook of Innovative Programs For The Impaired Elderly. Eloise H. P. Killeffer, Ruth Bennett, and Gerta Gruen. \$22.95.

Psychosocial Issues In The Treatment of Alcoholism. David Cook, Shulamith Lala Ashenberg Straussner, Christine Huff Fewell. \$8.95.

Occupational Therapy Strategies And Adaptations For Independent Daily Living. Florence S. Cromwell. \$19.95.

Recreation For The Disabled Child. Donna B. Bernhardt, editor. \$17.95.

McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020.

The Diagnosis & Treatment of Alcoholism. Second Edition. Jack H. Mendelson, M.D. and Nancy K. Mello, Ph.D., editors. \$34.95.

Jossey-Bass Inc., Department 62425, P. O. Box 62000, San Francisco, CA 94162-0425.

The Training In Community Living Model: A Decade Of Experience. Leonard I. Stein, Mary Ann Test, editors. \$8.95.

Longman, Inc., Distribution Center, 95 Church Street, White Plains, NY 10601.

Aspects Of Manipulative Therapy. E. F. Glasgow, L.T. Twomey, E.R. Scull, A.M. Kleynhans, and R. M. Idczak, editors. \$27.00

Handbook Of Private Sector Rehabilitation. Lewis J. Taylor, Ph.D, Marjorie Golter, Gary Golter, and Thomas E. Backer, Ph.D., editors. Springer Publishing Company, 536 Broadway, New York, NY 10012. \$32.95.

The editors date the beginning of private sector rehabilitation as 1975 when the State of California "enacted the first mandatory Workers' Compensation vocational rehabilitation program." Before that date "there were only a few rehabilitation practitioners in private practice scattered around the country."

This book, then, can be considered a survey of where the practice is and where it is expected to go. But between a recapitulation of the past and a prognostication of the future, its 14 chapters comment on such areas as "providing rehabilitation services to the insurance industry," "the rehabilitation counselor as an expert witness in personal injury litigation," and the use of computers and professional training in the area.

Annual Review of Rehabilitation. Volume 4, 1985. Elizabeth L. Pan, Ph.D., Shelia S. Newman, Thomas E. Backer, Ph.D., and Carolyn L. Vash, Ph.D., editors. Springer Publishing Company, 536 Broadway, New York, NY 10012. \$33.95.

This fourth volume of a continuing series presents 8 chapters by 12 authors and accents the rehabilitation of older people and the chronic schizophrenic client. There is also a chapter on head injury and an update on independent living concerns.

AMERICAN REHABILITATION, VOLUME 10 Numbers 1-4

Author Index

	Months	Page			
ADLER, Edna	J-F-M	19	PARENT, Wendy	J-A-S	11
BOURGEA, Ron	J-A-S	18	PARKER, Harry	O-N-D	18
	O-N-D	4	PARRINO, Sandra	J-A-S	3
BROWN, Dale	A-M-J	29	RALPH, Jack	O-N-D	13
CHAN, Fong	O-N-D	28	ROCHLIN, Jay	J-A-S	5
CONN, George	J-A-S	12	SANDERS, G. Earl	A-M-J	8
EISENBERG, M	O-N-D	6	SHANAHAN, Timothy	J-F-M	9
ELMORE, Jane	J-F-M	28	THOMAS, J. Paul	O-N-D	26
EVERSON, Jane	J-A-S	11	TOUBBEH, Jamil	J-F-M	3
GODDARD, Graham	A-M-J	13	ULICNY, Gary	A-M-J	18
GREGORY, James	J-F-M	9	WALBERG, Herbert	J-F-M	9
HASAZI, Susan	J-A-S	9	WEHMAN, Paul	J-A-S	11
IRWIN, Judy	A-M-J	26		A-M-J	4
JONES, Michael	A-M-J	18	WEISS, Cheryl	J-F-M	24
KALLSEN, Patricia	J-A-S	25	WILL, Madeleine	J-A-S	Cov.II
KIDDER, SUSAN	J-A-S	25	WILLIAMS, John	A-M-J	21
McCOLLUM, S	O-N-D	18		O-N-D	22
MELIA, Richard	A-M-J	4	WOOD-PIETRUSKI, Wendy	J-A-S	11
			ZITTEL, Gail	J-A-S	21

AMERICAN REHABILITATION Volume 11 Nos. 1-4 1985

Content Listing

	Months	Page		Months	Page
ADMINISTRATION			Electronic Communications	O-N-D	13
Perspectives on transition	J-A-S	25	Assisted Job Placement	O-N-D	18
The legislative process	J-F-M	28	BARRIERS	O-N-D	13
ATTENDANTS, management	A-M-J	18	BLIND		
AUTOMATION			Summer work program	A-M-J	26

Health care technicians	J-F-M	24	ENGINEERING, employing the disabled	A-M-J	13
CALIFORNIA			ILLINOIS, legislative process	J-F-M	28
Work-Ability	J-A-S	21	INDEPENDENT LIVING attendant management	A-M-J	18
Interaction between rehab and education	A-M-J	8	INDIANS, handicapping and disabling conditions in Native American Population	J-F-M	3
CASE HISTORIES			INTERVIEW with Sandra Parrino	J-A-S	3
Speech Products Impact Rehab Field	A-M-J	21	JOB ACCOMMODATION NETWORK	J-A-S	6
Employing the disabled	A-M-J	13	JOB CLUB	O-N-D	6
Story of David	J-A-S	18	JOB COACH		
COMPUTERS			The job coach	A-M-J	4
Employing the disabled	A-M-J	13	Supported employment	J-A-S	12
Speech products impact rehab	A-M-J	21	LEGISLATION, process	J-F-M	28
Voice Activated Computer	O-N-D	18	MENTAL ILLNESS	O-N-D	6
Reviews: 3 books	A-M-J	29	MINNESOTA blind health care technicians	J-F-M	24
Assisted Job Placement	O-N-D	18	NATIVE AMERICANS, handicapping and disabling conditions in population	J-F-M	3
DEAF			OCCUPATIONAL THERAPY blind and visually impaired health technicians	J-F-M	24
Interaction between rehab and education	A-M-J	8	OREGON, summer work program	A-M-J	26
Review: Speaking Language of sign	J-F-M	19	PSYCHIATRICALY IMPAIRED	O-N-D	6
EMPLOYMENT			PHYSICAL THERAPY, blind and visually impaired health care technicians	J-F-M	24
Supported Employment	J-A-S	12	REVIEW: Beyond Bureaucracy	O-N-D	4
Job accommodations network	J-A-S	6			
The job coach	A-M-J	4			
Employing the disabled	A-M-J	13			
Speech products impact rehab	A-M-J	21			
Summer work program	A-M-J	26			

SIGN LANGUAGE, review: speaking the language of signs	J-F-M	19	Summer work program	A-M-J	26
			Blind and visually impaired health care technicians	J-F-M	24
SPEECH, profile of speech- disabled sophomores	J-F-M	9	Voice Activated Computer	O-N-D	22
SPINAL CORD INJURY	O-N-D	26	Vocational Assistance For Vets	O-N-D	6
SUPPORTED EMPLOYMENT	J-A-S	12	TRANSITION Entire issue	J-A-S	1-32
SWITZER, Mary	O-N-D	4	Policies and Practices	J-A-S	9
TRAINING			VIRGINIA, Voc. Assistance	O-N-D	6
Interaction between rehab and education	A-M-J	8	WISCONSIN, perspectives on transition	J-A-S	25
Enhancing attendant manage- ment	A-M-J	18	WORK-ABILITY	J-A-S	21

Planning And Operating Group Homes For The Handicapped.

Grace Strano Youngblood and Gerard J. Bensberg. Research and Training Center in Mental Retardation, Box 4510, Lubbock, Texas 79409. 264 pages: \$10.

From the Introduction: "The text is directed toward service providers, advocacy groups, administrators, and other interested parties who are given the task of setting up independent living facilities for the developmentally disabled. The book is practical in application with emphasis placed on the group home concept of alternative living arrangements.

"(Its) six chapters ... detail ... areas of concern the service provider will more than likely have to deal with as he attempts to set up group homes. ... (which) include funding sources, zoning regulations, strategies for overcoming restrictive zoning, ICF/MR rules and regulations, AC MRDD standards for quality programming, staff training and orientation, model facilities and supervision, staffing patterns, staff/tenant relation-

ships, housing considerations, accessibility considerations, community resistance and acceptance, the law's effects through legislative and court rulings, etc. The appendices include an annotated bibliography, sample fire-safety code regulations, and state agency addresses for further sources of information on the independent living movement."

Water Sports for the Disabled. British Sports Association for the Disabled (B.S.A.D.) Sterling Publishing Company, Inc., 2 Park Avenue, New York, New York 10016. 255 pages. \$16.95.

This handbook was written by a team of experts in each water sport covered: swimming, canoeing, rowing, yachting, sailing, coastal cruising, scuba diving, fishing, power boating, and water skiing. Many of the writers are themselves disabled. They give detailed information on physical requirements, special equipment and facilities, and safety, as well as instruction, training, and techniques for each sport.

Additional chapters treat the dangers of hypothermia; the use of appropriate clothing, life jackets and buoyancy aids; insurance; how to handle and maneuver a disabled person; and suitable activities for people with mental handicaps.

Wheelchair Posture and Pressure Sores. Dennis Zacharkow, R.P.T. Charles C Thomas, Publisher, 2600 South First Street, Springfield, Illinois 62717. 99 pages. \$16.75.

This book explores wheelchair sitting posture as a major etiologic factor in pressure sore formation. Following an introduction on the prevalence and medical expense of pressure sores among the spinal cord injured, chapters detail proper sitting posture for able-bodied individuals, inherent problems with the wheelchair as a seat, essential modifications for proper seating posture, pelvic obliquity and pressure sores, wheelchair cushion selection, acute care considerations, and pressure sore recurrences. The application of posturing principles to other patient populations concludes the text.

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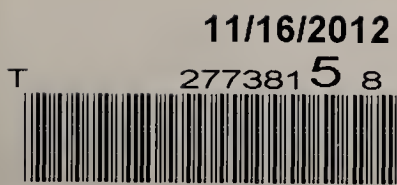
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